HOOSIER CRESCENT FOUNDATION CORPORATION

(A Not-for-Profit Organization)

Mission: to provide health services to the underserved and uninsured community of Indianapolis, Indiana

Dear Prospective Medical Provider:

Please find enclosed the volunteer application and the list of credentialing materials required by the federal government for physicians and physician assistants to provide medical services at the HCF Free Clinic. With this application you acknowledge that you understand HIPPA requirements and other general requirements for practice of medical profession in US and the State of Indiana.
Read the attached Physician Credentialing Information and provide the following information:

1. Signed copy of HCF – Appointment of Credentialing Agent – Form 1
2. Completed Copy of Personal Data - Form 2
3. Completed & signed copy of HCF – Health Survey Questionnaire - Form 3
4. Completed copy of Practitioner Questionnaire – Form 4
5. Completed copy of Safe Conduct Certification and Authorization – Form 5
6. Please provide a copy of the following:
    a. Driver's License
    b. Medical Board Certification
    c. School of Medicine Diploma
    d. Curriculum vitae
    e. Hepatitis Immunization Record
    f. Tuberculosis Screening Results
    g. CPR Training Certificate

With this application you acknowledge that you will follow HCF policies and guidelines for the operation of Free Clinic which will include Clinic Dress Policy, Release of information for Clinic Publicity, etc.

Thank you for your interest in volunteering with HCF Free Clinic.

Sincerely,

Hoosier Crescent Foundation (HCF) – Board of Directors

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Credentialing and Privileging of health care professionals

Initial Credentialing

The initial credentialing includes:

1. Primary source verification of:
    a) Current licensure; and
    b) Relevant education, training, or experience.
2. Secondary source verification of:
    a) Identification (via a government issued picture ID);
    b) Drug Enforcement Administration registration, as applicable;
    c) Hospital admitting privileges, as applicable;
    d) Immunization and TB skin test result status; and
    e) Life support training, as applicable.
3. Additional verification by:
    a) Querying the National Practitioner Data Bank (NPDB), as applicable (if HCF is ineligible to query the NPDB, the physician will provide the results of a self-query); and
    b) Determining practitioner's health fitness or the ability to perform the requested privileges (this is determined by a statement from the individual that is confirmed either by the director of a training program, chief of staff/service of a hospital where the individual has privileges, or a licensed physician designated by HCF);

***NOTE**: Reassessment of the Credentials and Privileges of practitioner every 2 years*

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Appointment of Credentialing Agent

I hereby consent to the disclosure, copying and transmission of information and documents related to my credentials, qualifications, conduct and performance by my credentialing agent (HCF). The exchange will be for any credentialing/re-credentialing applications and evaluations regarding my professional training, experience, character, conduct, judgement, ethics, ability to work with others, health issues, sanctions, against, or loss of licensure, or other items needed to complete my credentialing.

As a volunteer I will safeguard, privacy of patients, confidentiality of patients, confidentiality of patient records, and other policies and procedures implemented by HCF. HCF will protect my credentialing information from being disclosed to other entities not part of HCF or the credentialing process. I am informed and knowledgeable that federal and state laws provide immunity protections to HCF individuals for their acts and/or communication in connection with evaluating the qualification of health/medical professionals. I hereby release all HCF persons and entities from any liability that might occur for their acts and/or communication regarding evaluation of my qualification.

I understand and agree that, as an volunteer applicant, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications, and or resolving any doubt about such qualification or the ability to practice in a safe and effective manner.

I hereby authorize HCF or its designee to act as my agent in all matters related to credentialing/re-credentialing until I revoke this authorization in writing or until such time I no longer want to participate as a volunteer at HCF Free Clinic.

Printed Name: _____

Signature: _____

Date:_____

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Personal Data Form

1. Name: _____
2. Other name(s) previously used: _____
3. Gender: _____ Date of Birth: _____
4. Phone - (home): _____ (cell): _____
5. Home Address: _____
6. Place of Employment: _____
7. Medical License #: _____
8. Board Certification: _____
9. Medical specialty: _____
10. Hospital Privileges: _____
11. Any Medical Practice Restrictions: _____
12. Have you ever been named in a malpractice suit: YES _____NO_____
13. Emergency Contact – name/phone #: _____
14. Language spoken (other than English): _____
15. References - (name & phone #):
    a. _____
    b. _____
16. Email address: _____
17. Place of Birth – (country): _____
18. Citizenship: _____

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Health Survey Questionnaire

I am informed and believe, to the best of my knowledge that I do not have any contagious disease or other health condition posing a risk of transmission to patients, staff, or other volunteers.

Volunteer Name: _____

Signature: _____

Date:_____

(Provide a copy of Hepatitis immunization & tuberculosis screening results/records)

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Practitioner Questionnaire: Version 2018-1

A. Has your license to practice medicine in any jurisdiction ever been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, otherwise limited or have you ever been issued a citation or letter of reprimand by the licensing agency? YES _____ NO_____

B. Has your medical staff membership or medical staff status at any hospital or comparable acute or long term care facility or ambulatory surgery center or comparable facility, ever been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended or limited, based on patient care or professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced? YES _____ NO _____

C. Have your admitting or clinical privilege(s) at any other hospital, or at any comparable acute or long term care facility, or ambulatory surgery center or comparable facility, ever been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or limited, based on patient care or professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced? YES _____ NO _____

D. Have you ever voluntarily or involuntarily relinquished medical staff membership or status, admitting or clinical privileges, withdrawn an application for membership or privileges at any hospital or comparable acute or long term care facility, or ambulatory surgery center or comparable facility, after notification of the actual or imminent commencement of a formal or informal review, or investigation of your practice, credentials or professional conduct? YES _____ NO _____

E. Has your membership, participation, privileges, contractual affiliation or other status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization, or any other comparable health care entity ever been denied, revoked, voluntarily or involuntarily terminated, suspended, or limited based upon patient care or professional conduct grounds, or have formal or informal proceedings, or investigations toward any of those ends ever been commenced? YES _____ NO _____

F. Have you ever voluntarily or involuntarily relinquished membership, participation, privileges, a contractual affiliation or other comparable status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization, or any other comparable health care entity after notification of

the actual or imminent commencement of a formal or informal review or investigation, of your practice or professional conduct? YES _____ NO _____

G. Has your membership or status in any state or local professional society or other comparable medical organization ever been denied, revoked, voluntarily or involuntarily terminated, suspended or restricted based upon patient care or professional conduct concerns, or have formal or informal proceedings, or investigations toward any of those ends ever been commenced? YES _____ NO _____

H. Has your status as a participating provider in the Medicare, Medicaid, or Tricare (formerly Champus) programs ever been sanctioned, denied, suspended, voluntarily or involuntarily, limited or revoked, or have formal or informal proceedings, or investigations toward any of those ends ever been commenced? YES _____ NO _____

I. Has a letter of concern or reprimand ever been issued to you? YES _____ NO _____

J. Have you ever been denied professional liability insurance or has your policy ever been cancelled? YES _____ NO _____

K. (1) Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense of sexual misconduct? YES _____ NO _____

L. (2) With regard to any suit, has it resulted in a judgment, a settlement, or other final disposition (or is it still pending)? YES _____ NO _____

M. Does your professional liability (malpractice) coverage (if you still are covered elsewhere) exclude you from performing any specific procedures(s) or practicing portions of your specialty for which you are requesting privileges? YES _____ NO _____

N. Has your specialty board certification or eligibility ever been denied, revoked, voluntarily or involuntarily terminated, suspended, or have formal or informal proceedings or investigations toward any of those ends ever been commenced? YES _____ NO _____

O. Has your Drug Enforcement Agency or other controlled substances authorization ever been denied, revoked, voluntarily or involuntarily terminated, suspended, or restricted or have formal or informal proceedings, or investigations toward any of those ends ever been commenced? YES _____ NO _____

P. Have you ever been convicted of a criminal offense other than a minor traffic violation? YES _____ NO _____

Q. Are you now or have you ever been addicted to a controlled substance or alcohol?
YES _____ NO _____

R. Do you have any mental or physical condition that may significantly affect your ability to practice medicine? If so, do you believe that, with reasonable accommodation, you will be able to provide primary care at the HCF Clinic? YES _____ NO _____

PRINTED NAME: _____

SIGNATURE & DATE: _____

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Safe Conduct Certification and Authorization

To demonstrate the pro-active concern of the HCF for the safety of children entrusted to its' care at HCF facilities/clinics, the Board of Directors of HCF require that: board members, paid staff, and volunteers certify that they are free of suspicions of child abuse. The HCF and its advisors seek the following information for internal use.

1. Has any criminal charge, alleging sexual or other forms of child abuse, ever been filed against you by any child protective agency, prosecutor, or other public authorities in Indiana or elsewhere?
   YES _____ NO _____
2. Has any demand for payment of damages ever been made against you, or has any civil lawsuit ever been filed against you in Indiana or elsewhere seeking damages for alleged sexual or other forms of child abuse?

   YES _____ NO _____

3. Have you ever left or been removed from employment or from a volunteer position or been disciplined by any employer or organization because of charges of sexual or other forms of child abuse?

   YES _____ NO _____

NOTE: If you answered "YES" to any of the above questions you will be contacted by a HCF representative.

I certify that my answers to the above questions and any statements of explanation made by me on the form or any attached pages are true and accurate. I hereby recognize my duty and agree to make amendments to my answers above if there is a change of circumstance that renders my answers above untrue or incorrect. I hereby consent and grant permission to HCF authorities to obtain, for internal use only, any additional information relating to the information sought in this Consent form all pertinent organizations and individuals. I waive and release any and all claims I might have against any parties making such disclosures. I also waive and release any and all claims I might have against the HCF and its representatives relating to any such disclosures from third parties.

PRINTED NAME: _____

SIGNATURE & DATE: _____