INTEGRIS
Medical Group

INTEGRIS MEDICAL GROUP PACKET

INTEGRIS MEDICAL GROUP
APPLICANT CONSENT AND RELEASE

I hereby apply for appointment, privileges, and /or participation as requested above. I am willing to make myself available for interviews in regard to this application.

As an Applicant, I have the burden of producing adequate information for proper evaluation of my application. I also agree to provide INTEGRIS Medical Group with updated current information as it becomes available and such additional information as may be requested by IMG or its authorized representatives. Failure to produce this information or additional information will prevent my application from being evaluated and acted upon.

Information given in or attached to this application is accurate and fairly represents the current level of my training, experience, capability and competence to practice the clinical privileges or omission from this application, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application resulting in denial of appointment and clinical privileges. In the event that appointment or privileges have been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may result in immediate termination of such appointment for privileges.

By applying for appointment and clinical privileges, I accept the following conditions during the processing and consideration of my application, regardless of whether or not I am granted appointment for privileges, and for the duration of such appointment as I may be granted:

(a) I extend immunity to, and release from any and all liability, IMG, its authorized representatives and any third parties, as defined in subsection (c) below for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, performed, made requested or received by IMG and its authorized representatives to, from or by any third party including otherwise privileged or confidential information, relating but not limited to, the following: (1) Applications for appointment, appointment or clinical privileges, including temporary privileges; (2) periodic reappraisals undertaken for appointment or for change in clinical privileges; (3) proceedings for suspension or reduction of clinical privileges for denial or revocation of appointments or any other disciplinary sanction; (4) summary suspensions; (5) hearings and appellate reviews; (6) medical care evaluations; (7) utilization reviews; (8) any other Hospital, Medical Staff, service or committee activities; (9) matters or inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and (10) any other matter that might directly or indirectly have an effect on my competency or orderly operation of this or any other Hospital or health care facility.

In addition, the foregoing shall be privileged to the fullest extent permitted by law. Such privilege shall extend to IMG and its authorized representatives, and to any third parties. Such immunity shall apply so long as (i) IMG and its authorized representatives take such actions in compliance with the policies and procedures and related documents, and (ii) so long as third parties refrain from furnishing false information, if such third party knows such information is false.

(b) I specifically authorize IMG and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics behavior or any other matter bearing on my satisfaction of the criteria for initial or continued appointment to the Medical Staff, as well as to inspect or obtain any and all communications, reports records, statements, documents, recommendations or disclosures of said third parties relating to such questions. I also specifically authorize said third parties to release said information to IMG and its authorized representatives upon request.

(c) The term "IMG and its authorized representatives" mean IMG and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct in the clinic: the members of IMG's Board and their appointed representatives, the President of INTEGRIS Health or his or her partners, associates or designees, and all appointees to IMG's Medical Staff. The term "third parties" means all individuals, including appointees to IMG's Medical Staff, and appointees to the medical staffs of other hospitals or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether hospitals, health care facilities or not, form whom information has been requested by IMG or its authorized representatives or who have requested such information from IMG and its authorized representatives.

I acknowledge that the (1) Medical Staff appointment and clinical privileges at IMG are not a right of every licensed professional who makes application for the same; (2) my request will be evaluated in accordance with prescribed procedures defined in IMG's policies & procedures; (3) all recommendations relative to my application are subject to the ultimate action of IMG whose decision shall be final; (4) I have the responsibility to keep this application current by informing IMG, through the Vice President of IMG of any change in my professional liability insurance coverage, the filing of a lawsuit against me and any change in my medical staff status at any other hospital; and (5) appointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of IMG, as evidenced by admission, treatment and continuous care and supervision of patients for whom I have

responsibility and acceptable performance of all responsibilities related thereto as well as the other factors deemed relevant by IMG. Appointment and continued clinical privileges shall be granted only on formal application, according to IMG Policies & Procedures, and upon final approval of IMG Board.

I have received and had an opportunity to read the policies and procedures of IMG presently in force. I specifically agree to abide by all such policies, directives and rules and regulations as are in force during the time I am appointed or reappointed to IMG medical staff or exercise clinical privileges at the clinic.

If appointed or granted clinical privileges, I specifically agree to (1) refrain from delegating responsibility for diagnosis or care of IMG patients to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised; (2) refrain from deceiving patients as to the identity of any practitioner providing treatment or services; (3) seek consultation whenever necessary or required; (4) abide by generally recognized ethical principles applicable to my profession; (5) provide or arrange for the provision of continuous care and supervision as needed to all patients in the clinic for whom I have responsibility; accept committee assignments and such other duties and responsibilities as shall be assigned to me by the IMG Board and Medical Operating Committee.

APPLICANT'S AUTHORIZATION

I authorize IMG and its representatives to maintain information concerning my age, training, board certification and licensure in a centralized physician database for the purpose of making aggregate physician information available for credentialing use by INTEGRIS.

I agree to appear for a personal interview at any time if requested by any IMG representative.

I consent to the reporting by any authorized IMG representative of information to the National Practitioner Data Bank established pursuant to the Act which such IMG representative believes in good faith is required by law to be reported.

I agree to report to the Vice President of IMG any formal disciplinary action taken for professional conduct or current competence reasons, and the nature of and basis for the action, taken by any hospital, medical facility, disciplinary board or licensing board, or any voluntary reduction or resignation of medical staff privileges taken to avoid any investigation or disciplinary action. Failure to report such action, reduction or resignation in writing within fifteen (15) days of the event will be considered cause for automatic termination.

INTEGRIS MEDICAL GROUP (IMG)
APPLICANT'S CONSENT AND RELEASE
-PAGE 4-

I agree that, if any adverse recommendation or decision is proposed or made with respect to me

(i) I will follow and exhaust the administrative remedies afforded by IMG policies and procedures and related documents which shall be the exclusive remedy afforded to me as to such recommendation or decision and (ii) I will have the burden of demonstrating that I meet the standards for appointment or continued appointment to IMG or for the clinical privileges requested.

I understand and acknowledge that any controversy, dispute or disagreement remaining after the final decisions of the authorized Board Committee of IMG in connection with any hearing conducted pursuant to IMG policies & procedures and the hearing procedure, or the subject matter thereof, shall be settled exclusively by binding arbitration, which shall be conducted in Oklahoma City, OK, in accordance with the National Health Lawyers Associate ("NHLA") Alternative Dispute Resolution Service Rules of Procedure for arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.

Date: _____ Signature: _____

INTEGRIS Medical Group
Supplemental Application
for Clinical Privileges

Please complete this Supplemental Application and return it with your application. This information is required to determine if you have a physical or mental condition that could affect your ability to exercise the privileges requested and/or what accommodations are necessary and/or reasonable to allow you to practice safely and competently. This information will be kept in a confidential manner and will be considered only after preliminary approval of your appointment.

I. HEALTH STATUS

A. Date of last complete physical examination: _____

B. Present health status: _____Good _____Fair _____ Poor

C. Have you been hospitalized at any time during the past five years? _____ Yes _____ No

D. Have you ever been denied health, life or disability insurance? _____ Yes _____ No

E. Do you have any limitations on your health, life or disability insurance? _____ Yes _____ No

F. Are you currently using any illegal drugs? _____Yes _____ No

G. Have you ever had any problems with alcohol or drug dependency? _____ Yes _____ No

H. Are you currently taking any medication that may affect either your clinical judgment or motor skills? _____ Yes _____ No

I. Are you currently under the care of a physician? _____ Yes _____ No

If yes, please provide an explanation. Additional information may be requested. _____

_____

Date: _____ Signature: _____

_____
Printed Name

==========

To be completed by your physician or a peer within your office.

I hereby confirm, based on my observation, to the best of my knowledge, or discussion with peers, that no health problems exist that could adversely affect his/her ability to practice the privileges requested. _____ Yes _____ No

Date: _____ Signature: _____

_____
Printed Name & Institutional Affiliation

If no, please provide an explanation. _____

_____

INTEGRIS
Medical Group

I, _____ shall use my electronic or computer generated signature to authenticate my entries in the medical records I generate. My signature shall be generated by a confidential code, which only I have access to. No one other than myself will be allowed to use the signature.

_____

Signature

_____

Date

Physicians Personal Contact Information

Name: _____

Mailing Address: _____
(For all correspondence)

Suite /Apt #	City	State	Zip Code

Home Phone	Cell Phone

e-mail address

What is your preferred method of contact?_____

INTEGRIS

Signature Validation Log

Please provide all variations of your signature on the lines below. Add lines as needed.

_____

Printed Name

_____

Credentials

_____

Initials

_____

Signature

_____

Signature Variation

_____

Date

Disclosure Questions and References

Question:		Yes	No
1.	Have any disciplinary actions **ever** been initiated or are any pending against you by any licensure board?		
2.	Has your license to practice **ever** been or is it currently in the process of being denied, limited, suspended, revoked or terminated (whether voluntarily or involuntarily)?		
3.	Have you **ever** been, or are you currently in the process of being denied, limited, suspended, revoked, investigated or terminated by your medical specialty board (whether voluntarily or involuntarily)?		
4.	Have you **ever** been or are you currently in the process of being suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (for example, Medicare, Medicaid)?		
5.	Have you **ever** been or are you currently in the process of being the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program?		
6.	Have you **ever** been or are you currently in the process of being charged with or convicted of a crime (other than misdemeanor traffic violations)?		
7.	Has your professional liability insurance coverage **ever** been or is it currently in the process of being terminated by action of the insurance company?		
8.	Have you **ever** been or are you currently in the process of being denied professional liability insurance coverage?		
9.	Has your present professional liability insurance carrier **ever** excluded, or is it currently in the process of excluding any specific procedures from your coverage?		
10.	Have any professional liability suits **ever** been or are there any currently in the process of being filed against you? **If you have ever had ANY malpractice claims, see last page of this processing information form and copy as necessary for each case.**		
11.	Have any judgments or settlements **ever** been or are there any currently in the process of being made against you in any professional liability cases?		
12.	Has your employment, Medical Staff appointment or privileges **ever** been or are they currently in the process of being suspended, diminished, revoked, refused or terminated (whether voluntarily or involuntarily) at any hospital or other health care facility?		
13.	Have you **ever** withdrawn your application for appointment, reappointment and/or clinical privileges or resigned from the Medical Staff before a decision by a hospital's or health care facility's governing board was rendered?		
14.	Have you **ever** been or are you currently in the process of being the subject of an investigation and disciplinary proceedings at any hospital or health care facility?		
15.	Have you **ever** been or are you currently in the process of being denied appointment or renewal thereof, or been subject to disciplinary proceedings in any professional organization?		

If you have answered yes to any of the above questions, please provide full explanation of the details on the separate sheet provided.

REFERENCES

List at least three practitioners who have an active practice and who have had significant work experience with you, have observed your professional performance in the recent past and who can provide reliable, non-confidential information as to your training, clinical experience and ability, ethics, character, ability to work with others and other qualifications for appointment.

- **These references must not be relatives but should be peers in the same discipline.**
- **One of these references must be your training director from your most recent training program, if completed within the past five years.**
- **One must be your department chairman at your current hospital or clinical affiliation, if applicable.**
- **One must be your department chairman at your most recent past facility (if within the past 3 years). Otherwise, the person should be a peer that has a current working relationship with you and can attest to your performance.**

Provide **current, complete** mailing addresses, including zip code. **Providing fax numbers and e-mail addresses will expedite the application process.**

Please check which one applies: Chairman: ☐ Program Director: ☐ Peer: ☐

1. Name: _____ Specialty: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Facility: _____

   Telephone: _____ Fax: _____ Email: _____

Please check which one applies: Chairman: ☐ Program Director: ☐ Peer: ☐

2. Name: _____ Specialty: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Facility: _____

   Telephone: _____ Fax: _____ Email: _____

Please check which one applies: Chairman: ☐ Program Director: ☐ Peer: ☐

3. Name: _____ Specialty: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Facility: _____

   Telephone: _____ Fax: _____ Email: _____

Disclosure Questions and References
Supplemental Form

Please use this form to report any "Yes" responses to one or more of the Disclosure Questions. Record the question number in the first column, then your explanation on the lines provided. If you need additional space to explain a "Yes" response, photocopy this page as needed and submit.

Question #: **Explanation:**

_____ _____

_____

_____

_____

Question #: **Explanation:**

_____ _____

_____

_____

_____

Question #: **Explanation:**

_____ _____

_____

_____

_____

Question #: **Explanation:**

_____ _____

_____

_____

_____

Malpractice Claims Information

Name of Patient: _____

Allegation:

Your relationship to patient (attending, surgeon, assistant surgeon, consultant, etc.):_____

Date of incident: _____Date reported:_____

Location of incident:_____

Insurance carrier:_____

Additional defendants:_____

_____

CLAIMS STATUS: Open Closed Date: _____

If closed, indicate method of closing: Dismissal Settled Judgment

Amount of settlement or judgment: _____

Describe your care and treatment of the patient. (If additional space is necessary, use the reverse side or attach additional sheets.) Your narrative must provide adequate clinical detail to allow proper evaluation by a committee of physicians and include the following information:

Condition and diagnosis at time of incident:

Dates and description of treatment rendered:

Condition of patient subsequent to treatment:

PLEASE DUPLICATE AS NECESSARY

INTEGRIS MEDICAL GROUP
DELINEATION OF CLINICAL PRIVILEGES

APPLICANT:_____**DATE:** _____
(PRINT NAME)

PRIVILEGES ARE SITE SPECIFIC TO: _____
(FACILITY NAME)

TYPE OF REQUEST: NEW ☐ RENEWAL ☐ CHANGE ☐

SPECIALITY:_____**BOARD CERTIFIED: YES** ☐ **NO** ☐
SUBSPECIALITY:_____**BOARD CERTIFIED: YES** ☐ **NO** ☐

It is understood that the below list of procedures is representative of medical practice known for Primary Care and should not be construed as containing all such procedures in that area. Procedures indicated are representative of the practitioner's capability. Privileges for Physicians shall be granted solely on the basis of training and experience in given areas.

This listing of privileges is not intended to limit the ability or the responsibility of the Primary Care physician in performing this evaluation or determining the appropriate disposition of each patient. Application for the privileges to perform a specific procedure is understood to include application for the privilege to utilize such techniques, supplies, instruments and equipment as are inherent in this procedure.

PLEASE MARK THE PROCEDURE(S) FOR WHICH YOU ARE QUALIFIED AND REQUESTING AS CLINIC PRIVILEGES.
ALL BOXES MUST BE COMPLETED

Unless Specifically limited in the description of the privileges, privilege requests apply to:
☐ Adult Patients ☐ Pediatric Patients ☐ Adolescent Patients

REQUESTED	NAME OF PRIVILEGE	APPROVED	DENIED
	GENERAL PROCEDURES		
☐	HISTORY AND PHYSICAL EXAMINATION	☐	☐
☐	INTERPRETATION OF LABORATORY DATA	☐	☐
☐	INTERPRETATION OF RADIOGRAPHS/EKGS	☐	☐
☐	CARDIOPULMONARY RESUSCITATION	☐	☐
☐	Other:_____	☐	☐
	MANAGEMENT OF CONDITION, DISEASES & DISORDERS		
☐	CARDIAC DISEASES	☐	☐
☐	COLLAGEN DISEASES	☐	☐
☐	EYES, EARS, NOSE & THROAT DISEASES	☐	☐
☐	FEMALE REPRODUCTIVE DISEASES	☐	☐
☐	GASTROINTESTINAL DISEASES	☐	☐
☐	HEMATOLOGICAL DISEASES	☐	☐
☐	IMMUNOLOGIC DISEASES	☐	☐
☐	INTEGUMETRY DISEASES	☐	☐
☐	INFECTIOUS DISEASE	☐	☐
☐	METABOLIC/ENDOCRINE DISEASES	☐	☐
☐	MUSCULOSKETAL DISEASES	☐	☐
☐	NEUROLOGICAL DISEASES	☐	☐
☐	PULMONARY DISEASES	☐	☐
☐	RENAL DISEASES/GENITOURINARY	☐	☐
☐	ROUTINE PHYSICAL EXAMINATION/PREVENTIVE HEALTH	☐	☐
☐	OTHER:_____	☐	☐

INTEGRIS MEDICAL GROUP
DELINEATION OF CLINICAL PRIVILEGES

REQUESTED	NAME OF PRIVILEGE	APPROVED	DENIED
	OB/GYN		
☐	PERFORM PAP SMEARS	☐	☐
☐	PLACEMENT/REMOVAL OF IUD'S	☐	☐
☐	PROVIDE FAMILY PLANNING COUNSELING	☐	☐
☐	OB /ANTEPARTUM AND POSTPARTUM CARE	☐	☐
☐	OTHER:_	☐	☐
☐		☐	☐
	PEDIATRICS		
☐	MEDICAL PEDIATRIC CARE, INCLUDING IMMUN.	☐	☐
☐	ROUTINE NEWBORN CARE	☐	☐
☐	CIRCUMCISION	☐	☐
☐	OTHER:_____	☐	☐
	ANESTHESIOLOGY		
☐	LOCAL INFILTRATION AND MINOR NERVE BLOCK	☐	☐
☐	OTHER:_____	☐	☐
	OPHTHALMOLOGY		
☐		☐	☐
	GENERAL EVALUATION & TREATMENT OF OCCULAR DISORDERS		
☐	OTHER: _____	☐	☐
	ORTHOPEDICS		
☐	GENERAL ORTHOPEDIC EVALUATION AND TREATMENT	☐	☐
☐	JOINT INJECTION/ASPIRATION	☐	☐
☐	TREATMENT OF SIMPLE CLOSED FRACTURE, eg; Finger, Toe, Rib, etc.	☐	☐
☐	TRIGGER POINT INJECTIONS	☐	☐
☐	OTHER: _____	☐	☐
	SURGERY		
☐	I&D ABSCESS	☐	☐
☐	SUTURE OF LACERATIONS - SUPERFICIAL	☐	☐
☐	EVACUATION OF THROMBOSED HEMORRHOID	☐	☐
☐	VASECTOMY	☐	☐
☐	INTERMEDIATE REPAIR OF WOUNDS	☐	☐
☐	BIOPSY/EXCISION OF MALIGNANT OR BENIGN LESIONS	☐	☐
☐	EXCISION OF NAIL AND NAIL MATRIX	☐	☐
☐	OTHER:_____	☐	☐
	DERMATOLOGY		
☐	EVALUATION & TREATMENT OF SIMPLE/SUPERFICIAL SKIN LESIONS ACNE, ETC.	☐	☐
☐	OTHER:_____	☐	☐

INTEGRIS MEDICAL GROUP
DELINEATION OF CLINICAL PRIVILEGES

REQUESTED	NAME OF PRIVILEGE	APPROVED	DENIED
	COSMETIC PROCEDURES		
☐	MICRODERMABRASION	☐	☐
☐	COLLAGEN REMODELING	☐	☐
☐	LASER COSMETICS	☐	☐
☐	BOTOX INJECTIONS	☐	☐
☐	SCLEROTHERAPY	☐	☐
☐	OTHER:_____	☐	☐
	DIAGNOSTIC PROCEDURES		
☐	ALLERGY TESTING	☐	☐
☐	FLEXIBLE SIGMOIDOSCOPY & BIOPSY	☐	☐
☐	TREADMILL TESTS	☐	☐
☐	COLPOSCOPY & BIOPSY	☐	☐
☐	FINE NEEDLE ASPIRATION	☐	☐
☐	HOLTER MONITOR INTERPRETATION	☐	☐
☐	OTHER: _____	☐	☐

A Physician may request a change in his/her privilege status at any time by submitting a written request to the Medical Operating Committee so long as proper documentation of current or new clinical competence or training is provided.

I have not requested privileges for any procedures for which I am not qualified. Furthermore, I realize that certification by a Board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have requested privileges.

_____ _____

PROVIDER SIGNATURE DATE

The above applicant's training and competencies have been reviewed. Following presentation and review of the credentials and requested privileges.

_____ Privileges have been granted
_____ Privileges have been refused.
_____ Additional information requested:

Comments:_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

IMG Credentialing Community Chair Chief Physician Executive, IMG

_____

Date

Appointment expires: _____