The following documents must be obtained as part of the
Bread for the City provider application and credentialing process.

Please include them with your credentialing packet:

Required Documentation	**Included**	**N/A**
Copy of All Active State Licenses (please list below)		
Current Curriculum Vitae (Resume)		
Copy of Valid Driver's License or Non-Driver's ID		
Copy of Board Certification (MD, DO)		
If Foreign Medical Graduate ~ Copy of ECFMG		
Copy of Graduate School Diploma (NP/PA)		
Copy of NP/PA Certification		
Copy of DEA Certificate		
Copy of DC Controlled Substance Certificate		
For PA's - Copy of Collaborationg Physician License		
For PA's - Copy of Collaborationg Physician DEA Certificate		
Copy of CPR or ACLS Certification Card		
Completion of entire packet, dated and signed as indicated		

Name of Applicant: _____

Medical Clinic Provider Information

Name (first, middle, last)_____

Home Address_____

_____

City_____ State___ Zip_____

Home Phone_____

Work Address_____

_____

Work Phone_____

Please use ____ home ___office address for all mailings.

Cell Phone_____

Pager_____

Email_____

DOB____/____/____

SS Number _____-____-_____

National Provider Identifier # _____

UPIN # _____

Citizenship_____

Languages Spoken Fluently_____

Today's Date:_____

For Office Use Only

□ Interview	□ Temporary Approval Given
Date _____	Date _____
□ Orientation to Bread for the City	□ Final Approval given by Board of Directors
Date _____	Date _____
□ Orientation to Medical Clinic	□ Temporary Approval of Application for Reappointment
Date _____	Date _____
□ Given Patient Rights and Responsibilities	□ Final Approval of Application for Reappointment
Date _____	Date _____

Education and Post Graduate Training

Please complete the following information and submit an updated CV or résumé

Undergraduate Institution: _____ City, State: _____

Degree Obtained / Major: _____ Dates of Attendance: (mm/yy) ____/____ to ____/____

Medical/Professional School: _____City, State: _____

Degree Obtained: _____ Dates of Attendance: (mm/yy) ____/____ to ____/____

Internship (type of program): _____ Institution: _____

City, State: _____ Dates of Attendance: (mm/yy) ____/____ to ____/____

Residency (type: medical, surgical, etc.): _____ Institution: _____

City, State: _____ Dates of Attendance: (mm/yy) ____/____ to ____/____

Fellowship/Other: _____ Institution: _____

City, State: _____ Dates of Attendance: (mm/yy)____/____ to ____/____

Clinical Work History

List in chronological order all current & past clinical positions since completion of training or specialty degree obtained

Practice Name: _____ City, State: _____

From (mm/yy)____/____ to ____/____ Type of Practice/Privileges: _____

Practice Name: _____ City, State: _____

From (mm/yy)____/____ to ____/____ Type of Practice/Privileges: _____

Practice Name: _____ City, State: _____

From (mm/yy)____/____ to ____/____ Type of Practice/Privileges: _____

Practice Name: _____ City, State: _____

From (mm/yy)____/____ to ____/____ Type of Practice/Privileges: _____

Please attach additional information as needed

PROFESSIONAL PEER REFERENCES

Please list the name and complete address of two professional peer references. These individuals should be clinicians and be able to provide reference to your education, professional experience, clinical ability, ethical character, mental/physical health status, and ability to work with others.

Name:_____Title:_____

Address:_____

City/State/Zip_____

Phone #: _____ Fax #: _____

E-mail: _____

Name:_____Title:_____

Address:_____

City/State/Zip_____

Phone #: _____ Fax #: _____

E-mail: _____

I authorize the above named individual to complete a reference on my behalf.

_____

Signature

_____

Printed Name Date

_____

Limitations of Practice Checklist

Please answer the following questions:

1. Provider type: ___ Physician ___ Physician Assistant ___ Nurse Practitioner ___ Nurse

2. Has your license or certificate to practice your profession in any jurisdiction ever been limited, suspended or revoked, voluntarily or involuntarily? ___ No ___ Yes

3. Has your membership status and/or clinical privileges at any hospital, practice organization, or other health care setting ever been suspended or revoked? ___ No ___ Yes

4. Has your membership/fellowship in any local, state, regional, national, or international professional organization ever been suspended or revoked? ___ No ___ Yes

5. Has your DEA license ever been limited, suspended or revoked? ___ No ___ Yes

6. Have you ever been declared ineligible by any specialty board? ___ No ___ Yes

7. Have you ever been suspended from any federal (Medicare) or state (Medicaid) government programs? ___ No ___ Yes

8. Have you ever had any malpractice actions filed against you? ___ No ___ Yes

9. Have you ever been convicted of a felony, misdemeanor or any other criminal offense? ___ No ___ Yes

10. Do you have a history of or are you currently engaged in any inappropriate and/or unauthorized use of drugs or alcohol? ___ No___ Yes

11. Are you aware of any health reasons why you will be unable to perform any of the essential functions of your position, with or without accommodation? ___ No ___ Yes

Please provide a written explanation for any "Yes" responses on a separate page

_____

Signature Date

PROFESSIONAL LIABILITY INSURANCE

What source will provide the professional liability coverage for your professional services provided to Bread for the City patients?

___ Free Clinic Liability Assistance Program

If the Free Clinic Liability Assistance Program will be providing your professional liability coverage, you must submit a signed, notarized statement of compliance with your application.

___ Professional liability coverage through my employer

If your place of employment will be providing your professional liability insurance, please attach proof of that coverage to this application along with a statement from your employer stating that it covers your professional activities at Bread for the City.

___ My own personal professional liability coverage

If your own professional liability insurance will be covering your activities at Bread for the City, please attach proof of that coverage.

Printed Name _____

Signature _____

STATEMENT OF FITNESS TO PRACTICE

Name: _____

Date of Birth: _____

The above named person is not currently suffering from any physical disability or illness, mental illness, or drug or alcohol abuse that would impair the proper performance of their duties and responsibilities as a member of the medical staff of Bread for the City.

Date: _____

Signature: _____

Printed Name: _____

Title: _____

Address: _____

_____

Phone Number: _____

Documentation of PPD Test

Name: _____

Date of Birth: _____

On _____ a PPD was placed on the above named patient.
Date

The PPD was read on _____
Applicant's Name

and was found to be Negative / Positive.

_____

Signature Date

_____

Printed Name

_____ _____

Title Contact Number

Continuing Medical Education Agreement

Bread for the City Medical Clinic requires that the following continuing medical education requirements be met by all professional staff and volunteers:

Physicians – 50 hours every 2 years (a minimum of 25 hours should be Category 1)

Nurse Practitioners – 150 hours every 5 years

Registered Nurses – 24 hours every year

I will fulfill the continuing medical education requirements listed above. I will provide copies of the certificates verifying the CME credits earned to the Medical Clinic Administrator.

Print Full Name: _____

Signature: _____

Date: _____

Confidentiality of Bread for the City Client Information

Staff and volunteers will respect the highly confidential nature of client information.

As part of your responsibilities at Bread for the City, you may become aware of highly personal client information. You may have access to the client records, including medical charts, legal and social service case files, and food and clothing records and related client files on the Bread for the City client database. Any inappropriate release of client information may result in immediate suspensions.
Client information will not be discussed in public areas, nor client records left unattended in public areas.

All correspondence, reports, and other loose sheets with client information will be considered part of a client's records and treated confidentially.

Messages concerning client information may be left at clients' homes with family members or on an answering machine. The messages may not reveal any specific client information but simply to "call Bread for the City." If a client requests that no phone contact be made, or circumstances dictate extra caution with communication, contact will be entirely in writing or upon return to Bread for the City.

In general, a written release of information request or a court order is required to release client information. Verbal reports may be given to other human service providers when urgent information is needed. In the case of Medical records, they can be sent without written permission to health care facilities that the patient was referred to from the clinic. If the patient requests, they may receive a copy of his or her own medical record to transfer care or see a referral specialist. A notation as to where the information has been sent will be recorded in the medical chart.

If you are in doubt as to whether or not information should be released to a person requesting it, consult your supervisor.

Signature: _____

Printed Name: _____

Address: _____

Date: _____

DELINEATION OF PRIVILEGES FOR PHYSICIANS

Applicant: Please check all privileges you are requesting in the "Requested" column ONLY. Indicate "N/A" where privileges are not requested. Return signed form along with your application materials to the Medical Clinic Administrator.

Professional Peer Reference: Please review the privileges and procedures "Requested" by the Applicant. Based on your judgment, if applicant is qualified for and capable of performing the privilege, check the "Approval" box. Please return the completed and signed Delineation of Privileges form along with the Professional Reference Questionnaire to the Medical Clinic Administrator.

Privileges / Procedures	Requested	Approval
1. Ambulatory General Medicine / Request consultation where specific subspecialty is appropriate. *		
2. Arthrocentesis		
3. Skin biopsy		
4. Breast aspiration		
5. Needle aspiration of subcutaneous lesion		
6. Subcutaneous local anesthesia		
7. Peripheral nerve blocks		
8. Incision and drainage of superficial skin lesions		
9. Injections		

* This category is for physicians with 3 years of Family Practice or Internal Medicine training.

Signature of Applicant Date

Printed Name of Applicant

Signature of Professional Peer Reference Date

Printed Name of Professional Peer Reference

Bread for the City Medical Clinic
Patient Rights and Responsibilities

Bread for the City is committed to providing high quality medical care for its patients. The staff and volunteers are dedicated to the principles listed below.

RIGHTS

1. Each patient will be served with dignity, respect, and compassion.

2. All staff and volunteers are responsible for creating and fostering an atmosphere of mutual acceptance and trust.

3. Health care providers will provide information concerning your diagnosis and treatment in terms you can understand.

4. Patients will receive information necessary to give informed consent prior to the start of treatment, except for emergency situations.

5. Patients can refuse treatment and will be informed of the medical consequences.

6. Privacy to the extent consistent with adequate medical care will be provided. Case discussions, consultation, examination and treatment are confidential and will be conducted discreetly.

7. Privacy and confidentiality of all records pertaining to your treatment will be respected.

8. A reasonable response to your request for services will be provided.

9. The identity, upon request, of all health care personnel assisting in your care will be provided.

10. Patients may refuse to participate in clinical research studies. Any research affecting care or treatment shall be performed only with informed consent.

11. Treatment without discrimination as to race, color, religion, sex, sexual orientation, national origin, source of payment, political belief or handicap will be provided.

RESPONSIBILITIES

1. Patients will provide to the best of their knowledge complete, accurate, information about matters relating to their health.

2. Patients will be considerate of the rights of other patients.

3. Patients will be considerate of the rights of the staff and volunteers.

4. To help the clinic provide the best possible care, patients will report recommendations, questions, and complaints to the staff as soon as possible.

Please advise the clinic staff if you need an interpreter

STATEMENT OF APPLICANT

FACTUAL INFORMATION

This application contains detailed and specific information relating to my character and professional competence. I represent and attest that the information provided in, or attached to, this application is complete and correct to the best of my knowledge. I acknowledge that the burden of producing adequate information for a proper evaluation shall rest with me. I fully understand that a condition of this application is that any misrepresentation, misstatement, or misleading omission can be cause for automatic and immediate rejection or termination or employment /volunteering with Bread for the City Medical Clinic.

APPLICANT RESPONSIBILITIES

I hereby agree to cooperate to be a participating provider in the Bread for the City agreements with entities to include but not limited to federal and state health programs.

I agree to subject my clinical performance to, and faithfully participate in, Bread for the City quality assurance programs.

CONSENT TO RELEASE AND OBTAIN INFORMATION

I authorize Bread for the City (BFC) or its designee, by signed contract, to make inquiries concerning me to any third party, institution, corporation, or organization, including but not limited to other hospitals, medical organizations, National Practitioner Data Bank (NPDB), and past and present malpractice carriers who may have information bearing on my professional competence, character and ethical qualifications for purposes of evaluating this application.

I understand that I may review information obtained by BFC in connection with this application except for information that cannot be disclosed by law, such as the NPDB report (I may request a copy of my NPDB report directly from the NPDB). I understand I have the right to correct erroneous information obtained in connection with this application.

I hereby authorize BFC to communicate any information that BFC may have or acquire to any third party, institutions, corporations, organizations, including but not limited to other hospitals, medical organizations, managed care plans, commercial insurers, NPDB, federal and state health programs like Medicare, Medicaid and Champus making legitimate inquiry concerning my clinical privileges, professional competence, character and ethics or for the purpose of enrolling and/or credentialing me as a participating provider through any Bread for the City agreements, where such communication is made in good faith and without malice.

Print Full Name: _____

Signature: _____

Date: _____