EMORY
JOHNS CREEK
HOSPITAL

6325 Hospital Parkway
Johns Creek, Georgia 30097
Phone 678-474-7000
emoryjohnscreek.com

Dear Provider,

Thank you for your recent inquiry in credentialing at Emory Johns Creek Hospital. Through our affiliation with Emory Healthcare, we are pleased to announce that our application process is now conducted on-line. To begin this process, please complete the attached Request for Application and return it to us, along with all requested attachments. Upon receipt of your request form, we will email you a link to complete the on-line application.

Please complete this pre-application and submit it to EJCH with copies of the following. Please fax or email these documents to us at 678-474-7196 or Serge.Rolin@emoryhealthcare.org.

- ☐ **Current Government Issued ID**
- ☐ **Current CV (month/year format) with the last 5 years of work history enclosed**
- ☐ **Proof of malpractice coverage - $1M/$3M with tail coverage**

Additional documentation or requirements, which will be required as part of the application/credentialing/privileging processes are:
For Providers Requesting Privileges

- ☐ Provider Patient Safety Module – to include FLU and TB documentation (required for all providers except Referral category) - www.emoryhealthcare.org/preventthespread
- ☐ Privilege Form (excluding Referral category) - you will be provided your Specialty specific privilege form with your application
- ☐ Volume/Case log form from primary facility – required when requesting privileges

Privilege Testing Requirements (*if specific privilege is requested*):

☐ Administration of Moderate Sedation and Analgesia – see privilege form

AND/OR

☐ Use of Laser Privileges – see privilege form

https://www.emoryhealthcare.org/app/providerassessment/credentialing/signin.faces

In making your request for an application to Emory Johns Creek Hospital Medical Staff, please be aware of several obligations of staff membership, which apply to eligibility requirements:

1. **Current, unrestricted license to practice medicine in the State of Georgia**
2. **Local DEA licensure**
3. **Completion of board certification requirements within the eligibility time period defined by the Emory Johns Creek Bylaws (within five years following completion of medical specialty and sub-specialty training). Specialty or Sub-specialty board recognized by the American Board of Medical Specialties (ABMS) or American Board of Podiatric Surgery (ABPS).**
4. **Professional Malpractice Insurance Coverage of $1M/$3M with tail coverage**
5. **Compliance with meeting requirements**
6. **Compliance with Emergency Department Call requirements of your Department and/or Section.**
7. **Care for unassigned patients (covering provider)**

You may view the current bylaws document at http://emoryjohnscreek.com/medical-professionals/credentialing.htmlwebsite.

You should receive an email with a link to the on-line application within 3 business days.
For credentialing approval, please allow 90 days from the date that the *completed application* and documents are submitted. Please note: Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn. If you have any questions, please do not hesitate to contact us. We look forward to working with you soon!

Sincerely,

Susan Lieberman
Medical Staff Coordinator
Office: 678.474.7036; Fax: 678.474.7034
Susan.Lieberman@emoryhealthcare.org

Serge Rolin
Verification Specialist – EJCH
Office: 678.474.7194; Fax: 678.474.7196
Serge.Rolin@emoryhealthcare.org

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REQUEST FOR APPLICATION
ALL INFORMATION IS REQUIRED

DATE PREAPPLICATION SUBMITTED: ___\ ___ \ ___ ESTIMATED START DATE: ___\ ___ \ ___

CREDENTIALING REQUEST (SELECT ONE):
☐ **New Hire/Initial Request** ☐ **Adding a Facility**

ENTITY REQUESTING (*Please indicate all entities for which you are requesting privileges)
☐ **Saint Joseph's Hospital** ☐ **Emory University Hospital (Emory Faculty Only)**
☐ **Emory Johns Creek Hospital** ☐ **Emory University Hospital Midtown**

PRIMARY FACILITY **-_____ (Please identify of the facilities listed, ONLY ONE primary facility)**

CATEGORY REQUESTING - FOR EJCH ONLY (*See category definitions page)
☐ **Active** ☐ **Courtesy** ☐ **Consulting** ☐ **Referral** ☐ **Coverage**
☐ **APP Category I, II, III: Category I** - Clinical Psychologists **Category II** – Midlevel/ Employed by Physician (AA, CNM, CRNA, NP, PA), Category **III**-Allied Health/Sponsored (CSA, RNFA, CSFA, OTC, RN)

What percentage of your clinical practice is expected to be performed at Emory Johns Creek Hospital?

	Percentage of Your Annual Practice (%)
Admissions	
Outpatient Procedures	
Inpatient Procedures – Primary Procedures: _____	
Inpatient Consultations	
Use of Hospitalist Service: Admission _____ % Consultation _____%	
Referring patients to EUHM Outpatient Infusion Center on EJCH campus	
Call Coverage – please submit a separate list of physicians in your call rotation	

PROVIDER FULL NAME (AS LISTED ON LICENSE):_____
PROVIDER TYPE/TITLE (MD, DO, PA, etc.): _____ DATE OF BIRTH: _____
GA LICENSE #: _____ DEA #: _____
SSN# (required): _____ - _____ - _____ NPI #: _____
***EMAIL ADDRESS: _____**
***Invitation will be sent to this email address to complete the application (must have provider's email address)**
Credentialing Contact (Name/Email/Phone): _____

PRACTICING DEPARTMENT/SPECIALTY: _____
NAME OF YOUR ABMS OR ABPS BOARD CERTIFICATION/ELIGIBILITY (Physicians Only):
_____

FOR BOARD ELIGIBLE PROVIDERS – INCLUDE GRADUATION DATE FOR RESIDENCY/FELLOWSHIP:
_____
PRIMARY SPONSORING PROVIDER(S) – *required for Category I – III providers:* _____
For MDs/DOs, please list your APP(s); For APPs, please list your sponsoring/alternate provider(s)._____
For MDs/DOs/DPMs (on EJCH staff)– please list your covering provider:_____
Is the provider's patient load more than 50% pediatrics (17 years and younger)? Yes No
Are you joining an existing Practice? Yes No
Have you ever been, applied to be, credentialed at any Emory Healthcare facility? Yes No
If yes, Facility Name: _____ Dates of affiliation: From _____ to _____

In addition to EJCH, where are you currently on staff, or are you planning to apply for medical staff membership/clinical privileges? _____
PRIMARY PRACTICE NAME: _____
ADDRESS (INCLUDING CITY/ZIP): _____
PHONE #: _____ FAX #: _____
CELL #: _____ TIN# (REQUIRED) _____
PROVIDER'S RESIDENCE ADDRESS (INCLUDING CITY/ZIP): _____
_____
PROVIDER'S RESIDENCE PHONE #: _____

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PRE-APPLICATION QUESTIONS

Please answer each of the following questions in full. If the answer to any of these questions is "YES," please attach additional information.

1. Has your professional liability insurance ever been terminated or not renew by action of the insurance company? *If yes, please provide date, name of company(s) and basis for termination or non-renewal separately*
2. Has your professional liability insurance ever been terminated or not renew by action of the insurance company? *If yes, please provide date, name of company(s) and basis for termination or non-renewal separately*
3. Have you ever been denied coverage? *If yes, please provide details separately.*
4. Has your present professional liability insurance carrier excluded any specific procedures from your insurance coverage? *If yes, please identify procedures and provide details separately.*
5. Have there *ever been* any professional liability (i.e. malpractice) claims, suits, judgments, settlements or arbitration proceedings involving you?
6. Are any professional liability (i.e. malpractice) claims, suits, judgments, settlements, or arbitration proceedings involving you *currently pending*?
7. Are you aware of any formal demand for payment or similar claim submitted to your insurer that did not result in a lawsuit or other proceeding alleging professional liability?
8. To your knowledge, have you ever been the subject of any type of investigation (including *Peer Review*) or *adverse action* (or is an investigation or adverse action *currently pending*) at *any hospita*l? *If yes, EJCH will send you additional release forms.*

	Yes	No
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

9. Have you ever been subject to voluntary or involuntary termination of medical staff membership or voluntary or involuntary denial, limitation, reduction, restriction, loss, or change of clinical privileges at:
    a. Any hospital or other health care institution?
    b. An education facility or program (medical school, residency, internship, etc.)?
    c. A professional organization or society?
    d. A private, federal, or state agency regarding your participation in a third party payment program (Medicare, Medicaid, HMO, PPO, PHO, PSHCC, network, system, managed care organization, etc.)?
10. Has your license to practice in any jurisdiction for any profession ever been voluntarily or involuntarily revoked, suspended, challenged, investigated, placed on probation, reduced, relinquished denied or not renewed or is such action currently pending?
11. Have you ever been asked to surrender your license or have you ever been reprimanded or otherwise sanctioned by, or had conditions placed on your license in any jurisdiction?
12. Has your narcotic license ever been voluntarily or involuntarily revoked, suspended, challenged, investigated, placed on probation, reduced, relinquished or not renewed in the past five years?
13. Has your application for clinical privileges or medical staff membership or change in staff category at any hospital or healthcare facility ever been denied in whole or in part or is any such action pending?
14. Have you ever resigned from a hospital or other health care facility medical staff to avoid disciplinary action, investigation, including Peer Review, or while under investigation or is such an investigation pending?
15. Have you ever been arrested or charged with any crime?
16. Are any criminal charges currently pending against you?
17. Have you ever been convicted of or entered a plea for any criminal offense (excluding parking tickets)?
18. Has a patient, practice employee, hospital employee or other physician ever lodged a complaint against you involving any of the following types of behavior: sexual harassment, using threatening, profane or abusive language, inappropriate physical contact with another individual, or any other type of disruptive behavior?

	Yes	No
9a.		
9b.		
9c.		
9d.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		

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WAIVER, ATTESTATION, and SIGNATURE

By submitting this pre-application, signing this attestation, I certify, agree, understand and acknowledge the following:

1. The information in this pre-application, including all subparts and attachments, is complete, current, correct, and not misleading.

2. Any misstatements or omissions (whether intentional or unintentional) on this pre-application may constitute cause for denial of my Application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement.

3. A photocopy of this pre-application, including this attestation, the authorization and release of information form and any or all attachments has the same force and effect as the original.

4. I have reviewed the information in this pre-application on the most recent date indicated below and it continues to be true and complete.

5. While this pre-application is being processed, I agree to update the information originally provided in this pre-application should there be any change in the information.

6. No action will be taken on this pre-application until it is complete and all outstanding questions with respect to the pre-application have been resolved.

7. This attestation statement and pre-application must be signed no more than 180 days prior to the credentialing decision date.

8. I release from any liability, to the fullest extent permitted by law, all persons and entities (individuals and organizations) for their acts performed in a reasonable manner in conjunction with investigating and evaluating my pre-application, application, and qualifications, and I waive all legal claims of whatever nature against the Healthcare Entity and its representatives and designated agents acting in good faith and without malice in connection with the investigation of this pre-application, application, and my qualifications.

9. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies. I agree to conduct my practice in accordance with applicable laws and ethical principles of my profession. I also agree to provide for continuous care for my patients.

10. Any investigations, actions or recommendations of any committee or the governing body of the Healthcare Entity with respect to the evaluation of this Application and any periodic reappraisals or evaluations will be undertaken as a medical review and/or peer review committee and in fulfillment of the Healthcare Entity's obligations under Georgia law to conduct a review of professional practices in the facility, and are therefore entitled to any protections provided by law.

I request an application for appointment to the Medical Staff of Emory Johns Creek Hospital.

Signature: _____ Printed Name: _____ Date: _____

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EMORY JOHNS CREEK HOSPITAL – MEDICAL STAFF BYLAWS
APPENDIX A
MEDICAL STAFF CATEGORIES SUMMARY – FYI Only

	Active	Courtesy	Consulting	Referral	Coverage	Honorary
Basic Requirements						
Number of hospital contacts/2-year	≥ 24	> 6 & < 24	NA	N	NA	N
Rights						
Admit	Y	> 6 & < 24	Y	N	P	N
Exercise clinical privileges	Y	Y	Y	N	P	N
May attend meetings	Y	Y	Y	Y	Y	Y
Voting privileges	Y	P	P	P	P	P
Hold office	Y	N, unless waiver	N, unless waiver	N, unless waiver	N, unless waiver	N, unless waiver
Responsibilities						
Serve on committees	Y	Y	Y	Y	Y	Y
Emergency call coverage	Y	FUC	N	FUC	P	N
Meeting requirements	Y	N	N	N	N	N
Dues	Y	Y	Y	Y	Y	N
Comply w/ guidelines	Y	Y	Y	Y	Y	N

Y = Yes N = No
P = Partial (with respect to voting, only when appointed to a committee) FUC = Follow-up care

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MEDICAL STAFF STATUS - EMORY JOHNS CREEK HOSPITAL

Please Note: All category requests must be approved by the Department Chair, Credentials Committee, Medical Executive Committee, and Advisory Board. Providers not meeting the criteria/qualifications for the category requested may be reassigned or deemed ineligible per the EJCH medical staff bylaws. Supporting documentation may be required by request.

___ ***ACTIVE*** **The Active staff category shall consist of practitioners who actively support the Medical Staff and the Hospital by contributing to efforts to fulfill Medical Staff functions. All active category practitioners are required to take Emergency Call Coverage if a formal schedule is created for their specialty. To qualify for the Active Staff category, the Medical Staff member must maintain more than twenty-four (24) cases per reappointment period, twenty-four (24) months of accumulated data, defined as management of patients and/or performance of inpatient/outpatient operative and other procedures.**

___ ***COURTESY*** **The Courtesy staff category shall consist of practitioners who may only occasionally provide hospital services for patients and have expressed a willingness to contribute to Medical Staff functions and/or demonstrated a commitment to the Medical Staff and Hospital through service on Hospital or Medical Staff committees. To qualify for the Courtesy Staff category, the Medical Staff member must maintain six (6) to twenty-four (24) cases per reappointment period, twenty-four (24) months of accumulated data, defined as management of patients and/or performance of inpatient/outpatient operative and other procedures. Courtesy Medical Staff members who exceed the patient care activity requirement for the management of patients or performance of inpatient/ outpatient operative and other procedures may be reassigned to the Active Staff category.**

___ ***CONSULTING*** **The Consulting staff category shall consist of practitioners of demonstrated professional ability and expertise who provide a service *not otherwise available or in very limited supply on the active staff* (should the service become readily available on the Active Staff, the Consulting Staff members would not be eligible to request continued Consulting Staff status at the time of their next reappointment). *Providers in this category must be willing to provide inpatient consultations at Emory Johns Creek Hospital when requested.***

___ ***REFERRAL*** **The Referral staff category shall consist of PCP practitioners ONLY (Internal Medicine/Family Medicine/Pediatricians) who desire to be associated with, but who do not intend to establish a clinical practice at, this Hospital. It is a membership-only category, with no clinical privileges being granted. The primary purpose of the Referral Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients for tests and treatments**

___ ***COVERAGE*** **The Coverage staff category shall consist of practitioners who desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Active Staff members who are members of their group practice or their coverage group.**
Name of Provider and/or Group Covering: _____

___ **HONORARY** **The Honorary Staff shall consist of practitioners who have retired from the practice of medicine in this Hospital after serving for more than 10 years and who are in good standing.**

___ ***ALLIED HEALTH***

_____ - Category I - Clinical Psychologists
_____ - Category II - Midlevel / Employed by Physician (AA, CNM, CRNA, NP, PA, Surgical Assists)
_____ - Category III - Allied Health / Sponsored (OTC, RN)

_____ _____

Print Name **Signature** **Date**