

**SUPPLEMENT TO STATE OF ILLINOIS  
HEALTH CARE PROFESSIONAL CREDENTIALING AND BUSINESS DATA  
GATHERING APPLICATION FORM**

<b>ATTACH  PASSPORT  SIZE PHOTO</b>
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Last Name (and Degree)	First Name	Middle Initial
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You are required to complete Parts A & B of the State of Illinois Application Form.

**Home Address # 1**

Street	City	State	Zip
Home Telephone	Cellular Phone Number	Long Range Pager	
Marital Status _____	Spouse's Name _____	First	Last Degree

**Home Address # 2**

Street	City	State	Zip
Home Telephone			

<b>FOR OFFICE USE ONLY</b>	Will applicant be an Advocate Employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<b>This application will be processed for the Advocate entities indicated below.</b>		
Advocate Bethany Hospital	Advocate Physician Group	Advocate Health Center Network Specialists
Advocate Christ Medical Center	Advocate Christ Health Partners, Ltd.	Advocate Health Center Specialists
Advocate Good Samaritan Hospital	Advocate Good Samaritan Health Partners, Ltd.	Dreyer Medical Clinic
Advocate Good Shepherd Hospital	Advocate Good Shepherd Health Partners, Ltd.	Midwest Center for Day Surgery
Advocate Lutheran General Hospital	Advocate Lutheran General Health Partners, Ltd.	Naperville Surgical Centre
Advocate Illinois Masonic Medical Center	Advocate Illinois Masonic Health Partners, Ltd.	Salt Creek Surgery Center
Advocate South Suburban Hospital	Advocate South Suburban Health Partners, Ltd.	Tinley Woods Surgery Center
Advocate Trinity Hospital	Advocate Trinity Health Partners, Ltd.	

**ONE CASE/LOCUM TENENS APPLICANTS**

For which type of temporary privileges are you applying (check and complete A or B)?

A.        **One Case Privileges** (providing care for one specific patient only)  
 Name of current medical staff member requesting the provision of care \_\_\_\_\_  
 Name of Patient \_\_\_\_\_ Hospital Location (Room #) \_\_\_\_\_  
 Type of care to be provided \_\_\_ consultation \_\_\_ procedure \_\_\_ other  
 If "procedure" describe \_\_\_\_\_  
 If "other", describe \_\_\_\_\_

B.        **Locum Tenens Privileges** (providing patient care services for a defined period of time, not to exceed 60 days in place of a current staff member)  
 Name of current staff member \_\_\_\_\_  
 Inclusive dates when current staff member will need a replacement: From \_\_\_\_\_ To \_\_\_\_\_

**PROFESSIONAL LIABILITY INSURANCE CARRIER - WHEN JOINING ADVOCATE**

**SPECIAL INSTRUCTIONS:**

Please note that your insurance certificate or face sheet **MUST** show the name of the covered practitioner. It is important that you keep a copy of the completed State of Illinois application, as it will not be available from Advocate Health Care.

Carrier: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip  
Policy Number: \_\_\_\_\_ Original Effective Date : \_\_\_\_\_ Exp. Date: \_\_\_\_\_  
mm/dd/yy mm/dd/yy

**SECTION E. HOSPITAL MEMBERSHIP – CURRENT AND PENDING (Page 13 of Application)**

Please provide the complete name of the Department Chairman and his/her FAX # for EACH hospital listed in the application.

A. Primary Hospital \_\_\_\_\_  
Department Chairman \_\_\_\_\_ FAX# \_\_\_\_\_  
First Name Last Name Degree  
B. Other Hospital Error! Reference source not found.  
Department Chairman \_\_\_\_\_ FAX# \_\_\_\_\_  
First Name Last Name Degree  
C. Other Hospital Error! Reference source not found.  
Department Chairman \_\_\_\_\_ FAX# \_\_\_\_\_  
First Name Last Name Degree

(Use additional sheets if more than three hospitals)

**SECTION F. HOSPITAL MEMBERSHIP – PREVIOUS (Page 14 of Application)**

Please provide the complete name of the Department Chairman and his/her FAX # for EACH hospital listed in the application.

A. Hospital \_\_\_\_\_  
Department Chairman \_\_\_\_\_ FAX# \_\_\_\_\_  
First Name Last Name Degree  
B. Hospital \_\_\_\_\_  
Department Chairman \_\_\_\_\_ FAX# \_\_\_\_\_  
First Name Last Name Degree  
C. Hospital \_\_\_\_\_  
Department Chairman \_\_\_\_\_ FAX# \_\_\_\_\_  
First Name Last Name Degree

(Include additional sheets if more than three hospitals.)

**SECTION J. PROFESSIONAL HISTORY - PAGE 19 OF APPLICATION**

8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgical center privileges or membership for any reason?  Yes  No

9. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled, relinquished and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn?  Yes  No

10. Has your federal DEA number and/or controlled substances license in any jurisdiction been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration?  Yes  No

If you answer “yes” to any of the above questions please complete Form A included in the application form.

11. Have any professional liability suits, actions and/or claims that have been filed resulted in a dismissal?  Yes  No

If you answer “yes” to the above question please complete Form B included in the application form.

## ADVOCATE HEALTH CARE NETWORK

### APPLICANT'S CONSENT AND RELEASE

I hereby apply for appointment, clinical privileges, or permission to practice. I am willing to make myself available for interview(s) in regard to this application.

As an applicant, I have the burden of producing adequate information for proper evaluation of my application. Failure to produce this information or additional information as requested will prevent my application from being processed, evaluated and/or acted upon and will be deemed a voluntary withdrawal, not a denial.

Information given in or attached to this application is accurate, complete, and fairly represents the current level of my training, experience, capability and competence to practice. As a condition of making this application, any misrepresentation or misstatement in, 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, clinical privileges and/or permission to practice. In the event that appointment, clinical privileges and/or permission to practice have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of such appointment, privileges or permission to practice.

I acknowledge that the credentialing, recredentialing and update forms are State forms and cannot be altered in structure or content. Such alteration will invalidate the form and will prevent it from being processed, evaluated and/or acted upon.

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

- (a) I specifically authorize Advocate Health Care Network and its authorized representatives to perform a criminal background check; to consult with any third party who may have information, including privileged or confidential information, which relates to my professional qualifications, credentials, clinical competence, character, current health status, ethics, conduct or any other matter required to satisfy the criteria for initial appointment to the medical staff, continued appointment to the medical staff, clinical privileges and/or permission to practice 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 Advocate Health Care Network and to its authorized representatives upon request
- (b) I acknowledge that any information described in (a) above from a third party or available from within Advocate Health Care Network may be shared among Advocate Health Care Network and its authorized representatives for the purposes described in (c) below.

If this application is being submitted to an AHCN PHO, I hereby authorize to the release of credentialing and business information by Advocate Health Partners to the managed care organizations with which it contracts for purposes of credentialing and participation in their health plans.

- (c) I understand that Illinois law grants immunity for credentialing and peer review activities except for willful or wanton misconduct, and to that extent I hereby release from liability, AHCN, and any third parties for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, performed, made, requested, or received by AHCN to, from or by any third party, including otherwise privileged or confidential information. These activities include, but are not limited to, the following:
  - (1) evaluation of applications for appointment, clinical privileges and/or permission to practice, including temporary privileges;
  - (2) periodic reappraisals undertaken for reappointment, increase or decrease in clinical privileges or permission to practice;
  - (3) any corrective action and any reviews of corrective actions affecting clinical privileges, membership, or permission to practice

- (4) quality evaluations;
- (5) utilization reviews;
- (6) any other hospital, facility, medical staff, department, service or committee activities;
- (7) matters or inquiries concerning my professional qualifications, credentials, clinical competence, character, current health status, ethics, conduct or any other matter that might directly or indirectly have an effect on my competence, on patient care or on the orderly operation of AHCN or any hospital or health care facility.

(d) The term "Advocate Health Care Network and its authorized representatives (AHCN)" includes each of the Advocate affiliates including those in or with which Advocate has an ownership interest or management contract and its directors, officers, medical staff members, attorneys, Governing Councils (and their members) and agents with any responsibility for obtaining or evaluating my credentials or acting on my appointment, permission to practice or conduct.

The foregoing shall be confidential to the fullest extent permitted by law.

I acknowledge that (1) appointment, clinical privileges, and /or permission to practice within AHCN is not a right of every licensed or non-licensed professional who makes application for the same; (2) my request will be evaluated in accordance with prescribed procedures defined in AHCN policies, medical staff bylaws, credentialing procedure manuals, and/or medical staff rules and regulations, (3) all recommendations relative to my application are subject to the ultimate action of AHCN, whose decision shall be final; (4) if accepted , my initial appointment, clinical privileges and/or permission to practice shall be provisional for the time period determined by AHCN; and (5) reappointment, continued clinical privileges and/or permission to practice remain contingent upon my continued demonstration of professional competence as evidenced by appropriate treatment and acceptable performance of all responsibilities related thereto as well as the other factors deemed relevant by AHCN. Reappointment, continued clinical privileges and/or continued permission to practice shall be granted only on formal application, according to state law, AHCN policies, bylaws, rules and regulations, and upon final approval of the governing board or designee.

I have received and had an opportunity to read a copy of bylaws, rules and regulations and/or credentialing policies presently in force which are applicable to me. I specifically agree to abide by all such bylaws, policies, directives and rules and regulations as are in force during the time I am appointed, exercise clinical privileges and/or have permission to practice within AHCN.

If appointed, granted clinical privileges or given permission to practice, I specifically agree to: (1) refrain from fee splitting or other inducements relating to patient referral; (2) refrain from delegating responsibility for diagnosis or care of hospitalized patients to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised; (3) refrain from deceiving patients as to the identity of any practitioner providing treatment or services; (4) seek consultation whenever necessary or required; (5) abide by generally recognized ethical principles applicable to my profession; (6) provide continuous care and supervision as needed to all patients in the hospital for whom I have responsibility; (7) accept committee assignment and such other duties and responsibilities as shall be assigned to me.

I also agree to provide AHCN, in the future, with updated, current information regarding all data on this application form and such additional information as may be requested by AHCN as follows: 1) within 5 business days for revocation, suspension or limitation of state health care professional license; state controlled substance license and/or federal DEA registration; Medicare or Medicaid sanctions; revocation, suspension or limitation of hospital privileges; any lapse in professional liability coverage or conviction of a felony and 2) within 45 days for any other change in information from the date I knew of the change.

Date \_\_\_\_\_ Signature \_\_\_\_\_

Print Name \_\_\_\_\_