Updated 04/17/2017

Specialty Surgery Center
322 22nd Avenue North | Nashville, TN 37203
(615) 321-6161 | fax (615) 645-9870 | www.ssctn.com

Re-Credentialing Application: Pediatric Dentist

Dear Pediatric Dentist,

Thank you for your continued interest in providing services at our facility. We have enjoyed participating in the care of your patients undergoing treatment at Specialty Surgery Center (SSC). In an effort to comply with State and Federal guidelines governing Ambulatory Surgery Centers, our Governing Board requires that all providers submit a re-credentialing application every two (2) years. Much of this application is an attestation and update of your Initial Application for Privileges. A copy of your Initial Application for Privileges can be provided upon request. In addition to the following application, you will need to submit the following documentation before your application is considered complete:

_____Updated copy of current Tennessee issued Professional License (Dental License)
_____Updated copy of current Professional Liability Insurance (Malpractice Insurance)
_____Updated copy of Loss History Report related to your Professional Liability Insurance
_____Copy of current BLS/CPR certification, ACLS &/or PALS (if applicable)
_____Updated list of facilities where you currently hold active privileges (if applicable)
_____Copy of DEA (if applicable)
_____$100 Re-credentialing application fee

The re-credentialing process will begin upon receipt of your complete Re-Credentialing Application as well as the Re-Credentialing Application fee of $100. This application should be submitted prior to expiration of your previously granted privileges. Once this application has been processed, privileges are again active for a period of two (2) years.

If you have any questions or need assistance with this application, please feel free to contact me via email at cdavenport@ssctn.com or phone at (615) 340-8510. We look forward to receiving your completed application and to working with you.

Sincerely,

Christina Davenport
Specialty Surgery Center

Re-Credentialing Application:
Pediatric Dentist

Section I: Demographic Information

Last Name | First Name | Middle Initial | Gender

______-______-______ Social Security Number

____/____/________ Date of Birth

Preferred Contact Method: E-mail Phone Fax

Primary Practice Name

Office Manager/Contact

Primary Practice Address | City | State | Zip

(______) ______ - ________ Practice Telephone

(______) ______ - ________ Practice Fax

E-mail Address

Emergency Contact Person

(______) ______ - ________ Emergency Contact Phone

Emergency Contact Relation To You

Section II: Professional License/Certification Information

(Attach copies of all licenses and certifications)

License Number: ______________Type:____________________Date Issued: ____/____/________ Expiration: ____/____/________

License Number: ______________Type:____________________Date Issued: ____/____/________ Expiration: ____/____/________

DEA/Controlled Substance Number: ____________________________ Expiration Date: ____/____/_________

BLS Certification Expiration Date: ____/____/________ ACLS Certification Expiration Date: ____/____/________

PALS Certification Expiration Date: ____/____/________

Specialty Board(s) by which you are certified: ____ Date certified:____/____/________

Date Certification Expires: ____/____/________ Have you ever taken & failed a professional certification examination? YES NO

If yes, please provide details: ____

Section III: Professional Liability Information
(Attach proof of liability insurance and loss history if applicable)

____ ______________________________
Current Liability Carrier Name Policy Number

____/____/________ ____/____/________ ______________________ ____________________
Policy Effective Date Expiration Date Per Occurrence Amount ($) Aggregate Amount ($)

Section IV: Additional Education & Employment Information

Since submitting your Initial Application for Privileges have you completed additional training recognized by an Accrediting Body (ie ACGME, CODA) YES NO

____ ___________________To___________________
Training Program Dates attended

____ ___________________To___________________
Training Program Dates attended

Please list your employment history for the previous two years, including your current employer:

Employer: ______________________________________ City/State: ______________________________________

Position: ______________________________________ Dates employed: _____________ to ___________________

Employer: ______________________________________ City/State: ______________________________________

Position: ______________________________________ Dates employed: _____________ to ___________________

If there has been any lapse in employment (>6 months) during the past two years, please explain:

____

____

Section V: Health Status & Personal/Professional Information
(If you answer "yes" to the following questions, please explain on separate sheet of paper)

Since your initial appointment, or last reappointment to Specialty Surgery Center, have any of the following been, or are actions pending or are any in the process of being: denied, revoked, suspended, reduced, limited, placed on probation, modified, not renewed, voluntarily or involuntarily relinquished?

1.	State medical/dental license (any state)	YES	NO
2.	Any other professional registration	YES	NO
3.	DEA Registration	YES	NO
4.	Membership on Active Staff (any facility)	YES	NO
5.	Clinical Privileges (any facility)	YES	NO
6.	Rights on any Medical Staff	YES	NO
7.	Other institutional affiliations or status	YES	NO
8.	Professional society membership	YES	NO
9.	Fellowship/Board certification or eligibility	YES	NO
10.	Professional liability insurance (malpractice insurance) *	YES	NO
11.	Driver's License	YES	NO

**-Any liability claim information should include names, dates, parties, clinical Summary, of events, disposition, current status and/or settlement amounts.*

Since your initial appointment, or last re-appointment to Specialty Surgery Center:

1. Have you been involved in any liability judgments, awards, or out of court settlements, or is any malpractice action currently pending? If "yes," answer how many below, if "No", skip to next question. YES NO

   How Many in last two (2) years? _______________

2. Have you been convicted of any crime, other than a minor traffic violation? YES NO

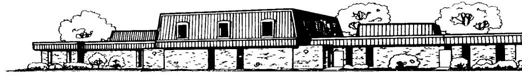
Section VI: Conditions of Application

I attest that the information contained in this profile and all enclosed/attached documents, which are agree to provide to support this profile, are complete and accurate. I agree to notify SSC of any change in the information contained in this profile and any attached documents within thirty (30) days of the date that I am aware of the change. Furthermore, I consent to the inspection and copying of all records and documents that may be relevant to my pending credentialing review and decision.

A copy of this authorization and release has the same effect as the original.

____ _______________________________
Printed name of Pediatric Dentist Applicant Date

____
Signature of Pediatric Dentist Applicant



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Privilege Delineation Form For: Pediatric Dentistry

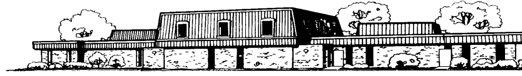
Name:____ Date:______________________________

Please check the requested privileges below:

Requested privilege	Official Use Only: Accept	Official Use Only: Denied
_______Fulfillment of general dentistry (reference General Dentistry Privilege Delineation Form)		
_______Dental treatment of handicapped children and adults		
_______Dental trauma, excluding the treatment or manipulation of fractures to the maxillofacial region		
_______Dental treatment of medically compromised children, including evaluation and treatment of Hematology/Oncology patients, including treatment and prevention of microstomia, therapy to increase oro-motor function and dental preventive care		

___________________________________ ___________________
Applicant's Signature Date

___________________________________ ___________________ ______________________
Governing Board Signature Date Approved? (YES or NO)



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Release of Information

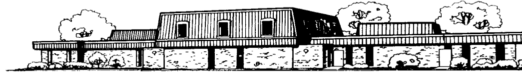
By making application to the Specialty Surgery Center as an Allied Health Professional, I hereby authorize the Corporate Compliance Officer, or their designee, to make an inquiry of any of my references and institutions in which I have been enrolled or by whom I have been employed or extended privileges, as to my qualifications.

I further authorize any of the above persons or institutions to forward any and all information their records may contain and agree to hold them harmless from any action by me for their acts.

A photocopy of this shall serve as the original.

____
Full Name (Printed)

____ ______________________________
Signature Date



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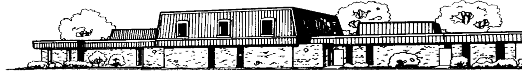
Total Release of Liability

I, ___________________________________, an Allied Health Professional of the Specialty Surgery Center (SSC), understand that SSC's first priority is to meet the needs of the patient. In meeting this goal, I understand that Specialty Surgery Center cannot be held responsible for any injury I may incur during my attending and/or assisting on surgeries while at their surgery center. In signing this form, I am relinquishing Specialty Surgery Center from any liability during my stay as an Allied Health Professional at Specialty Surgery Center.

____
Full Name (Printed)

____ _________________________________
Signature Date

____ _________________________________
Witness Signature Date



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Full Approval of Re-Appointment for:
Pediatric Dentist

(This Page Official Use Only)

____
Full Name (Printed)

______________________ ______________________
Re-Appointment Begins Re-Appointment Expires

Approved By Credentialing Staff:

____ ______________________________
Compliance Officer Signature Date

Approved By Governing Body:

____ ______________________________
President, Specialty Surgery Center Date

SPECIALTY SURGERY CENTER

PROVIDER/CRNA HEALTH SCREENING

Name: ____ SS#: __________________
Address: ____

Phone: _________________________________ DOB: ______________

Family
Doctor:___________________________Address:____
_______________________ Phone: _____________________

HEALTH HISTORY:
Allergies: ____________________________ Current Medications: _____________
____

Do you have or have you ever had the following: (yes or no)

Heart disease	________	Liver disease	________
Lung disease	________	Mental illness	________
Diabetes	________	Depression	________
Epilepsy	________	Musculoskeletal	________
Seizures	________	disease or injury	________
Cancer	________	Stomach or bowel	________
Tuberculosis	________	Renal disease	________
Hypertension	________	Fever/night sweats	________

What are your current immunizations? ____________________________________

List any major hospitalizations and any previous surgeries including year. Exclude childbirth.____
____
____

PHYSICAL EXAM:
HT: _____ WT: _____ BP: _____ P: _____ R: _____ Temp: _____ Sat: _____

Any recent illness? ____
Recent exposure to communicable diseases? ________________________________
Recent unexplained weight loss? ______ lbs __________over __________ months
Hepatitis B Series: Yes _____ No ______ Hep Titer results: _______ Date: _______
T.B. skin test date: __________ Site: ___________ Result: ______________________
Influenza vaccine: Yes _____ No ______ Date __________
Comments:

Examiners Signature: ____________________________________Date___________

Employee Signature: _____________________________________Date___________