Dear Physician/Surgeon,

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 (Medical 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) 321-6161 ext. 1001. We look forward to receiving your completed application and to working with you.

Sincerely,

Christina Davenport
Specialty Surgery Center
Re-Credentialing Application:
Physician/Surgeon

Section I: Demographic Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

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: _____________________________________________________________

S:\SSC\SSC Credentialing\Applications for Privileges\Re-Credentialing Application (Physician-Surgeon).docx
**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**
(Attach current Curriculum Vitae)

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:

________________________________________________________________________

________________________________________________________________________
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.
   How Many in last two (2) years? ______________
   YES  NO

2. Have you been convicted of any crime, other than a minor traffic violation?  
   YES  NO
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 Physician/Surgeon Applicant  Date

____________________________________________
Signature of Physician/Surgeon Applicant
Privilege Delineation Form For:
Oral & Maxillofacial Surgery

Name: ___________________________________ Date: ______________________

Please check the requested privileges below:

- Performance of History & Physical Exam
- Dentoalveolar surgery including exodontia and hard/soft tissue recontouring
- Maxillofacial trauma including placement of archbars,
- Treatment of maxillofacial pathology including removal of benign cysts/tumors of the jaws
- *Dental Implant Surgery
- **Maxillofacial Aesthetic Surgery including administration of Botox/Fillers

*Subject to review and approval of the Governing body
**Must show documentation of experience or fellowship completion prior to approval

| Official Use Only |
|-------|-------|
| Accept | Denied |

Applicant’s Signature ____________________________________________________________________ Date ____________________________

Governing Board Signature ___________________________________________________________________ Date ____________________________ Approved? (YES or NO) ____________________________

S:\SSC\SSC Credentialing\Applications for Privileges\Re-Credentialing Application (Physician-Surgeon).docx
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
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
Full Approval of Re-Appointment for:
Physician/Surgeon

(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)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease</td>
<td></td>
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<tr>
<td>Liver disease</td>
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<tr>
<td>Lung disease</td>
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<td>Mental illness</td>
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<td>Diabeteas</td>
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<tr>
<td>Depression</td>
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<td>Epilepsy</td>
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<tr>
<td>Musculoskeletal</td>
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<tr>
<td>Seizures</td>
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<tr>
<td>Disease or injury</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Stomach or bowel</td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Renal disease</td>
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<tr>
<td>Hypertension</td>
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<tr>
<td>Fever/night sweats</td>
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</tr>
</tbody>
</table>

What are your current immunizations? _______________________________________________________________________

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

PHYSICAL EXAM:

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___________

S:\SSC\SSC Credentialing\Applications for Privileges\Re-Credentialing Application (Physician-Surgeon).docx