Website: https://surgicoreasc.com

INITIAL CREDENTIALING APPLICATION

Please put a check next to the name of the facility to which you are applying:

(_) Surgicore of Jersey City Surgical Center	550 Newark Avenue, Jersey City, NJ 07306	Tel. (201) 795-0205
(_) Surgicore of Saddle Brook	444 Market Street, Saddle Brook, NJ, 07663	Tel. (201) 843-9441
(_) New Horizon Surgical Center	680 Broadway, Suite 201, Paterson, NJ 07514	Tel. (973) 782-4202
(_) Rockland And Bergen Surgery Center	133 N Kinderkamack Rd., Montvale, NJ 07645	Tel. (201) 307-4810
(_) Manalapan Surgery Center	50 Franklin Lane, #101, Manalapan Township, NJ 07726	Tel. (732) 617-5990
(_) Fifth Avenue Surgery Center	1049 Fifth Avenue, New York, NY 10028	Tel. (212) 772-6667
(_) Fifth Avenue Surgery Center Extension Clinic	305 E. 47th Street, New York, NY 10017	Tel (646) 233-5000
(_) AllCity Family Healthcare Center, Inc.	3632 Nostrand Avenue, Brooklyn, NY 11229	Tel. (718) 332-4409
(_) North Queens Surgical Center	45-64 Francis Lewis Blvd., St. 200, Bayside, NY 11361	Tel. (929) 258-7720
(_) Empire State Ambulatory Surgery	3170 Webster Avenue, Bronx, NY 10467	Tel. (718) 708-5777
(_) ASC of Rockaway	105-20 Rockaway Beach Blvd, Far Rockaway, NY 11694	Tel. (718-819-5448

Instructions:

Please complete all sections that are applicable and put notation "N/A" if not applicable and please see "CV" response is not acceptable. Kindly attach additional sheets if there is insufficient space on this form to complete your responses.

Please submit the completed, signed form along with appropriate clinical privileges (DOP) and copies of documents as follows.

- ☐ **Current Curriculum Vitae/Resume**
- ☐ **Current State License Registration Certificates, DEA Registration and applicable CDS for New Jersey location**
- ☐ **Current Professional Liability Insurance Coverage**
- ☐ **ECFMG Certificate, if applicable**
- ☐ **Copies of ALL Professional School Diplomas and Trainings (Internship, Residency & Fellowship)**
- ☐ **Current NYS Infection Control Certificate (for NY Location)**
- ☐ **Current ACLS, BLS, PALS, Hospital affiliation, if applicable**
- ☐ **Copies of CME Certificates and case logs for certain privilege requirements, please refer to DOP.**
- ☐ **Current Board Eligibility or Board Certification, if applicable**
- ☐ **Complete check marked, signed, and dated DOP & Attestation for "EACH FACILITY" of PREFERENCE**
- ☐ **Copies of Physical/Health Forms which include – Immunization/Titers (MMR & Hep B, Current Physical Assessment & Latest PPD (Chest X-Ray, Skin Test or QuantiFERON) and Seasonal Flu Shot**
- ☐ **Copy of COVID VACCINE CARD**
- ☐ **Two (2) Letters of Recommendation from Peers in the same field**
- ☐ **Current Valid photo ID (US Passport or Driver's License)**

To ensure smooth credentialing process, please submit all the above documents together with your completed application. Missing Information and Documents will lead to delays in processing your application. If you have any Questions or Concerns, please contact the Credentialing Department at Tel: (718) 332-4409 ext. 118 or 327. Please send your completed application via fax 347-492-7936 or email: mmaningas@afhcsurgery.com or maryann@afhcsurgery.com

Section 1 – PERSONAL INFORMATION

Last Name:	**First Name:**	**Middle Name:** **Suffix:**
Do you have another Name? YES: ___ NO: ___	**Other Last/First Name Used:**	**Home Address:** _____ _____
Date of Birth: **SSN: (Required)**	**Place and Country of Birth:**	
Gender Identity:	**Email Address:**	**Cell Number:** **Citizenship:**
Languages Spoken: _____	**Degree:** **Specialty:** _____ MD: __ DO: __ DPM: __ DC: __ PA: __ NP: __ CRNA: __ Others: __	
In case of Emergency (Notify): Name: **Relationship:** **Contact No.:**		

Section 2 – PROFESSIONAL INFORMATION

Federal DEA No:	**Issue Date:**	**Expiration Date:**	**DEA State of Registration:**
CDS Certificate No:	**Issue Date:**	**Expiration Date:**	**CDS State of Registration:**
State License No:	**Issue Date:**	**Expiration Date:**	**License Issuing State:**
Other State License No:	**Issue Date:**	**Expiration Date:**	**License Issuing State:**
NPI No:	**Medicaid No:**	**Medicare No:**	**Tax ID No:**
UPIN No:	**USMLE No:**	**ECFMG No:**	**ECFMG Issue Date:**

Section 3 – EDUCATION AND TRAINING INFORMATION

Pre-Medical School	**Address:**	**From:** **To:**	**Degree Awarded:**
Professional/Medical School	**Address:**	**From:** **To:**	**Degree Awarded:**
Post Medical School/Others	**Address:**	**From:** **To:**	**Degree Awarded:**
INTERNSHIP:			
Name of Institution:	**Address:**	**From:** **To:**	**Department/Specialty:**
Name of Institution:	**Address:**	**From:** **To:**	**Department/Specialty:**
RESIDENCIES:			
Name of Institution:	**Address:**	**From:** **To:**	**Department/Specialty:**
Name of Institution:	**Address:**	**From:** **To:**	**Department/Specialty:**

FELLOWSHIP:			
Name of Institution:	**Address:**	**From:** **To:**	**Department/Specialty:**
Name of Institution:	**Address:**	**From:** **To:**	**Department/Specialty:**

Section 4 – BOARD SPECIALTY INFORMATION

Primary Specialty:	**Board Certified** **Yes:** ____ **No:** ____	**Period (From-To):**
Secondary Specialty:	**Board Certified** **Yes:** ____ **No:** ____	**Period (From-To):**
If Not Certified, when is the expected date of exam:	**Name of specialty Board:**	

Section 5 – GAP HISTORY INFORMATION

(*If there is a break in the continuity of your medical education, internship, residency, hospital affiliations, medical practice, etc.,*)

Gap Start Date:	**Gap End Date:**	**Explanation/Reason:**
Gap Start Date:	**Gap End Date:**	**Explanation/Reason:**

Section 6– CURRENT HOSPITAL AND OTHER FACILITY AFFILIATIONS

Hospital/Facility Name:	**Address:**	**From-To:** ______________ **Department:**	**Privileges:** **Admitting:** __ **Voluntary:** __ **Courtesy:** __ **Others:** __
Hospital/Facility Name:	**Address:**	**From-To:** ______________ **Department:**	**Privileges:** **Admitting:** __ **Voluntary:** __ **Courtesy:** __ **Others:** __

Section 7 – CURRENT PRACTICE/WORK LOCATIONS

Name of Group/Practice:	**Address:** ___________________________ ___________________________ **Office Hours/Days:**	**Telephone No:** _____________ **Fax No:**	**Contact Person:** _______________ **Email Address:**
Name of Group/Practice:	**Address:** ___________________________ ___________________________ **Office Hours/Days:**	**Telephone No:** _____________ **Fax No:**	**Contact Person:** _______________ **Email Address:**
Name of Group/Practice:	**Address:** ___________________________ ___________________________ **Office Hours/Days:**	**Telephone No:** _____________ **Fax No:**	**Contact Person:** _______________ **Email Address:**

Section 8 – PROFESSIONAL LIABILITY INSURANCE

Carrier Name:	Address:	Policy No:	Policy Limit:	Date of Coverage:

Type of Coverage: **Claims ____** **Occurrence _____** **Retroactive Date: _____**

Section 9 – MALPRACTICE CLAIM HISTORY:

Please complete, if not applicable, put "N/A"

I. Name of Claimant: _____Date of Incident: _____Date Claim Filed: _____

State/County/District where Claim is Filed: _____Status of Claim: Pending___ Closed___

What was/is your status? Solo Defendant_____ Co-Defendant_____ Other_____

Allegations/Nature of Claim: _____

_____

_____

_____

II. Name of Claimant: _____Date of Incident: _____Date Claim Filed: _____

State/County/District where Claim is Filed: _____Status of Claim: Pending___ Closed___

What was/is your status? Solo Defendant_____ Co-Defendant_____ Other_____

Allegations/Nature of Claim: _____

_____

_____

_____

III. Name of Claimant: _____Date of Incident: _____Date Claim Filed: _____

State/County/District where Claim is Filed: _____Status of Claim: Pending___ Closed___

What was/is your status? Solo Defendant_____ Co-Defendant_____ Other_____

Allegations/Nature of Claim: _____

_____

_____

_____

Please add a separate sheet if there's not enough space.

Section 10 – PREVIOUS WORK HISTORY (WITHIN THE LAST 5 YEARS)

Facility Name:	**Address:**	**From:** **To:**	**Department:** **Tel. No:**
Facility Name:	**Address:**	**From:** **To:**	**Department:** **Tel. No:**
Facility Name:	**Address:**	**From:** **To:**	**Department:** **Tel. No:**

Section 11 – PROFESSIONAL REFERENCES (Minimum of Two (2) Peers are required for Validation of the Application)

Name:	**Address:**	**Contact No. & Email:**
Name:	**Address:**	**Contact No. & Email:**
Name:	**Address:**	**Contact No. & Email:**

Section 11 – HEALTH STATUS ATTESTATION

1. Do you currently have any physical or mental condition(s) that may affect your ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which you are applying for?

   (Note: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current participation in aftercare programs for alcohol, drug dependency, medical limitation or activity, workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.)

   ☐ **YES** ☐ **NO**

2. ***Are you able to perform all the essential functions of the position for which you are applying, safely and according to accepted standards of performance, with or without reasonable accommodation to be provided in the facility***?

   ☐ **YES** ☐ **NO**

_____ _____ _____

Name of Applicant Signature Date

Section 12 – DISCLOSURE/ATTESTATION QUESTIONS (PROVIDER REQUIRED RESPONSE):

If your answer to any of the following questions is "YES", please provide details and reasons, as specified in each question. Please provide additional sheet if needed and kindly sign and date each additional sheet.

1. Has your license, registration, or certification to practice in your profession, ever been voluntary or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?

   ☐ **NO** ☐ **YES, PLEASE EXPLAIN:** _____

2. Has there been any challenge to your licensure, registration, or certification and/or have any findings of professional misconduct or proceedings to that extent ever been instituted in this or any other State?

   ☐ **NO** ☐ **YES, PLEASE EXPLAIN:**_____

3. Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee or governing board?

   ☐ **NO** ☐ **YES, PLEASE EXPLAIN:** _____

4. Have you voluntarily or involuntarily surrendered, limited your privileges, or not reapplied for privileges while under investigation?

   ☐ **NO** ☐ **YES, PLEASE EXPLAIN:** _____

5. Has your Drug Enforcement Agency (DEA) or other controlled substances authorization ever been denied, revoked, suspended, reduced, relinquished, or not renewed, or have proceedings toward any of those ends ever been instituted?

   ☐ **NO** ☐ **YES, PLEASE EXPLAIN:** _____

6. Have you ever been terminated, suspended, sanctioned, disciplined, excluded or otherwise restricted from participating in any private, federal or state health insurance program (i.e., Medicare, Medicaid, or other third-party payment)?

   ☐ **NO** ☐ **YES, PLEASE EXPLAIN:** _____

7. Have you ever been convicted or, pled guilty to, or pled nolo contendere to any felony or have you ever been court-martialed for actions related to your duties as a medical professional?

   ☐ **NO** ☐ **YES, PLEASE EXPLAIN:** _____

Section 12 – DISCLOSURE/ATTESTATION QUESTIONS (PROVIDER REQUIRED RESPONSE) (Continuation):

8. Are you currently the subject of investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

   ☐ **NO** ☐ **YES, PLEASE EXPLAIN:** _____

9. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Date Bank?

   ☐ **NO** ☐ **YES, PLEASE EXPLAIN:** _____

10. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during trainings (internship/residency/fellowship, etc.)? Have any board certifications or eligibility ever been revoked?

    ☐ **NO** ☐ **YES, PLEASE EXPLAIN:** _____

11. In the past ten (10) years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

    ☐ **NO** ☐ **YES, PLEASE EXPLAIN:** _____

12. Have you had any professional liability actions (pending, settled, arbitrated, mediated, or litigated) within the past 10 years?

    ☐ **NO** ☐ **YES, PLEASE EXPLAIN:** _____

13. Has your present malpractice insurance carrier excluded any specific procedures from your coverage, ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?

    ☐ **NO** ☐ **YES, PLEASE EXPLAIN:** _____

14. Have you voluntarily changed your scope of practice with your insurance carrier (e.g., Major surgery vs. Minor surgery), and ever practiced without liability coverage?

    ☐ **NO** ☐ **YES, PLEASE EXPLAIN:** _____

I CERTIFY THE INFORMATION IS COMPLETE, CURRENT, CORRECT AND NOT MISLEADING. I UNDERSTAND AND ACKNOWLEDGE THAT ANY MISSTATEMENTS IN, OR OMISSION WILL CONSTITUTE CAUSE OF DENIAL OF MY APPLICATION OR SUMMARY DISMISSAL OR TERMINATION OF MY PRIVILEGES OR MEMBERSHIP. I HAVE REVIEWED THIS INFORMATION ON THE MOST RECENT DATE INDICATED BELOW AND IT CONTINUES TO BE TRUE AND COMPLETE. I AGREE TO UPDATE THE INFORMATION ORIGINALLY PROVIDED IN THE APPLICATION SHOULD THERE BE ANY CHANGE OF INFORMATION.

_____ _____ _____

CLAIMS HISTORY FORM

Please complete the form below authorizing your insurance carrier to submit a letter to us verifying your insurance and also to outline the nature of your malpractice claims for the past 5 years for appointment, or 2 years for reappointment, if any. The information requested is part of your appointment/reappointment and must be received by our office to expedite the process.

Below is a form letter for your convenience, which authorizes the release of this information to us. Thank you for your prompt attention to this matter.

AUTHORIZATION FOR RELEASE

Date: _____ Group Insured Through: _____

To: _____

Policy Period: _____ Policy Number: _____

Dear Sir or Madam:

Please submit a copy to the Credentialing Coordinator verifying my insurance and giving them a history of my past and present claims experience during the past 5 years. This information is needed as soon as possible for the appointment/reappointment process. Please send via email fax or mail. The information for the center is a follow:

The mailing address is as follow: _____
_____
_____

Email: _____

Thank you for your prompt attention in this matter.

_____ _____
(Signature) **(Date)**

_____
Printed Name