Application to join the Medical Staff of
Surgicore Surgical Center

Same-Day Ambulatory Surgery Center
23 Hour Stay Permitted
State Licensed by NJ DOHSS
Joint Commission Accredited
Medicare Certified
2 Operating Rooms

444 Market Street
Saddle Brook, NJ, 07663
Tel.:(201) 843-9441
Fax:(201) 843-9442

Surgicore Surgical Center

Required Documents for Privileges Application

- ☐ Resume/CV
- ☐ Completed & Signed Application (Attached), Listing what procedures each Doc intends to do
- ☐ Any & all awarded Diplomas (i.e. Medical School, Internship, Residency, Fellowship, Board Certification Letter)
- ☐ Hospital Affiliation Letter
- ☐ Any applicable Certificates of Training for Special Procedures
- ☐ Two (2) Reference Letters from Peers **(blank form provided)**
- ☐ Copy of NJ Medical License
- ☐ Copy of Malpractice Certificate of Insurance/ Binder showing Limits & Coverage Period
- ☐ Copy of Federal Drug Enforcement Authority (DEA) Certificate
- ☐ Copy of NJ Controlled Dangerous Substance (CDS) Certificate
- ☐ Completed & Signed Delineation of Privileges
- ☐ If Needed, Preference Card listing preferred supplies and/or equipment req'd in OR for cases
- ☐ Latest History & Physical, within 1 year **(blank form provided)**
- ☐ Titers/Vaccines for Measles, Rubella, Rubeola, Hepatitis
- ☐ Flu Shot within 1 year
- ☐ TB (Ppd) 2 Step tests, within 1 year
- ☐ ACLS & BLS Certificates Current (req'd for Anesthesiologist)

We will then conduct a NPDB search, Primary Source Verification via the AMA, NJ Medical License Verification & submit the Application for Committee Review.

The entire process normally takes approximately 1 week.

Thank you very much for your interest in our Facility!!

Any questions please do not hesitate to call & speak with me.

Best Regards,

Monique Morris, Administrator
Tel: (201) 843-9441
Fax: (201) 843-9442
Cell: (201) 403-5017

Leticia Hoyle, Director of Nursing
Tel: (201) 843-9441
Fax: (201) 843-9442
Cell: (917) 674-7696

GENERAL

NSTRUCTIONS

Complete the Application in full. Print or type all responses.
Attach additional sheets if necessary to complete your response & reference the question being answered. Submit photocopies of all other Required Documentation as per attached sheet.

PERSONAL INFORMATION

Physician Name

Office Address

Office Telephone | Office Contact | Office Email

Home Address

Home Telephone | Cell Phone | Personal Email

Birthplace | Date of Birth | Citizenship

EDUCATION

	School Name & Location	Degree	Dates Attended
Medical School			
	Institution & Address		Dates Attended
Internships			
Residencies			
Fellowships			
Preceptorships			

CURRENT HOSPITAL & SURGERY CENTER PRIVILEGES

Institution	Dates	Staff Status: Active, Courtesy
	From -to	
	From-To	
	From-To	
	From -- To	

BOARD CERTIFICATIONS

Board Name	Year Certified	Year Recertified

Active Candidate for Board of:

Name of Board | Date of Exam

LICENSING

New Jersey License No. _____ Date Issued _____

In what other States are you Licensed? _____

PROFESSIONAL LIABILITY INSURANCE

Carrier _____ $ Limits _____ Specialty & Special Procedures Included _____

Copy of Certificate of Insurance must be attached

STATEMENT OF HEALTH

Answer one (1) of the following:

1) I certify that I am in good health and have no physical or mental limitations. _____

2) I do have a chronic illness, physical disability or mental limitation to my health, which may include alcohol or drug abuse, but believe that this does not significantly impair my ability to render quality patient care. _____

If you answered #2 and there has been any significant change in your health status in the past two (2) years, a full statement of explanation must be attached. This statement must include the name and address of your personal PCP.

MEDICAL REFERENCES

List three (3) Peer References & their addresses/contact information:

1) _____

2) _____

3) _____

PROFESSIONAL STATUS

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES", PLEASE GIVE FULL DETAILS ON SEPARATE SHEET(S) OF PAPER.

Within the past six (6) years:

1) Has your license to practice medicine been voluntary or involuntary limited, suspended, revoked or restricted? ☐ Yes ☐ No

2) Has your license to prescribe narcotics been voluntarily or involuntarily refused, suspended or revoked? ☐ Yes ☐ No

3) Have you relinquished or reduced your privileges at any hospital or dropped any hospital from your practice? ☐ Yes ☐ No

4) Have you ever been denied requests for privileges at any hospital or surgery center? ☐ Yes ☐ No

5) Have you ever resigned or been asked to resign from a Medical Staff or a professional society? ☐ Yes ☐ No

6) Has any hospital or surgery center ever suspended, diminished, revoked, or failed to renew your privileges? ☐ Yes ☐ No

7) Have you ever been convicted of a crime (other than a motor vehicle citation)? ☐ Yes ☐ No

8) Have you ever been denied membership or renewal thereof, or been subject to Disciplinary proceedings in any medical organization? ☐ Yes ☐ No

9) Have you ever had professional liability insurance denied, cancelled, issued on special terms or renewal refused? ☐ Yes ☐ No

10) Do you have any malpractice claims pending? ☐ Yes ☐ No

Have you had any malpractice judgments or settlements made against you? ☐ Yes ☐ No

If "Yes" to either, please describe the date and nature of the alleged malpractice, name of insurance company defending you, settlement amount if settled, judgment amount or verdict if case went to trial, current status if case is not resolved.

STATEMENT OF APPLICANT

I fully understand that any significant misstatement in or omission from this application or any future application constitutes cause for denial of appointment to or dismissal from the Medical Staff. All information submitted by me in this application is true to the best of my knowledge and belief.

I have read the Bylaws and Rules and Regulations of the Medical Staff. In making application for appointment to the Medical Staff of *Surgicore Surgical Center,* I agree to abide by the Bylaws of the Medical Staff, as same may be amended from time to time, and by such Rules and Regulations as may be adopted in accordance with these Bylaws. I further agree to abide by all policies enunciated by the Medical Advisory Board of *Surgicore Surgical Center.*

I agree to carry at least minimum professional liability insurance in accordance with the Bylaws of the Medical Staff of *Surgicore Surgical Center.* I understand I am not permitted to exercise any clinical privileges until appropriate evidence of professional liability coverage has been submitted to the Medical Staff. I agree to notify *Surgicore Surgical Center* of any malpractice claim or suit that may be filed against me resulting from my practice either at *Surgicore Surgical Center* or elsewhere. Furthermore, should any malpractice insurance coverage be interrupted or terminated for any reason, I will notify the Medical Director immediately.

I hereby authorize *Surgicore Surgical Center,* its Medical Staff and their representatives to consult with administrators and members of the medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present professional liability carriers, who may have information bearing upon my professional competence, character and ethical qualifications. I further consent to the inspection by *Surgicore Surgical Center,* the Medical Staff and their representatives of all documents, including medical records at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges, and I hereby consent to the release of such information.

I hereby release from liability all representatives of *Surgicore Surgical Center* and its Medical Staff for their acts performed without malice in connection with evaluating my application and my credentials and qualifications,and I hereby release from any liability any and all individuals and organizations who provide information to *Surigcore Surgical Center* or its Medical Staff, without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges. and I hereby consent to the release of such information.

I hereby believe that I am qualified to perform all *Surgicore Surgical Center* procedures for which I have applied for in this application.

I agree that I shall not rebate a portion of a fee or accept other inducements in exchange for a patient referral, that I shall not deceive a patient as to the identity of an operating surgeon or any other medical practitioner providing treatment or services and that I shall not delegate the responsibility for diagnosis or care of patients to another medical practitioner unless I believe such practitioner to be qualified to undertake this responsibility.

_____ _____

Signature of Applicant Date

NOT TO BE FILLED IN BY APPLICANT

The attached privileges are recommended to the Board of Directors for:

☐ Approval as requested

☐ Approval with conditions as specified:

_____

_____

☐ Denial-Reason for denial:

_____

_____

_____

Date Signature-Medical Director

Surgicore
Surgical Center, LLC

DELINEATION OF PRIVILEGES
PRACTICE AREA: **GYNECOLOGY**

GYNECOLOGICAL PRIVILEGES – I am requesting Gynecology privileges for:

Requested	Not Req.	Granted	Procedure
☐	☐	☐	Dilation & curettage of the uterus and endo-cervical curettage
☐	☐	☐	Endometrial Ablation
☐	☐	☐	Biopsy & simple excision of masses of the anus, perineum, vulva, vagina, and cervix
☐	☐	☐	I & D vulvar/vaginal abcess, I & D marsuplialization Bartholins cyst/abcess
☐	☐	☐	Hyster-salpingogram (HSG), saline infusion sono-hysterogram (SIS)
☐	☐	☐	Colposcopy of cervix, vagina, vulva, anus, +/-biopsy
☐	☐	☐	LEEP or cold knife cone of the cervix
☐	☐	☐	Diagnostic Hysteroscopy
☐	☐	☐	Operative Hysteroscopy (removal sub mucosal fibroid/polyp with Resectoscope/Myosure
☐	☐	☐	Endometrial Ablation, (Thermachoice or Novasure)
☐	☐	☐	Diagnostic Cystocopy
☐	☐	☐	Diagnostic Laparoscopy
☐	☐	☐	Laparoscopic Tubal Ligation
☐	☐	☐	Trans-cervical sterilization
☐	☐	☐	Operative Lararoscopy:
☐	☐	☐	(a) Removal of ovarian/tubal cyst or mass
☐	☐	☐	(b) Aspiration of ovarian/tubal cyst
☐	☐	☐	(c) Removal of one or both ovaries
☐	☐	☐	(d) Removal of one or both fallopian tubes
☐	☐	☐	(e) Treatment of ectopic pregenancy (salpingostomy/salpingectomy)
☐	☐	☐	(f) Removal of Sub-serosal uterine fibroid
☐	☐	☐	(g) Laparoscopic supracervical Hysterectomy with or without removal of B/L ovaries and fallopian tubes
☐	☐	☐	Other:1.
☐	☐	☐	2.
☐	☐	☐	3.

I agree to admit patients, perform histories and physicals, order diagnostic tests, request consultations, provide consultations within the scope of my privileges, use all skills normally learned during medical school and residency, and render any care in a life-threatening emergency or as requested by the Clinical Administration should there be a physician crisis in the Facility.

I will practice within the bounds of my training and competence and will not attempt to treat cases which are not in my scope of practice. I understand that any newly developed treatment modalities are not included in this request and must be cleared by the Medical Executive Committee and Governing Board before their performance. I will become familiar with the capabilities and limitations of this Facility.

I understand that in making this request I am bound by the applicable Bylaws and/or Policies & Procedures of *Surgicore Surgical Center*, and hereby stipulate that I meet the threshold criteria for this request. I also certify that I have knowledge to operate all the equipment necessary to carry our requested procedures.

Date

Applicant's Signature

Applicant's Name Printed

Privileges:
Granted _____ Deferred _____ _____

Medical Director Signature Date

Modifications: _____

SURGICORE SURGICAL CENTER LLC

Pre-Employment Physical Form

Name: _____ D.O.B.: _____

Address: _____ City: _____ State: _____

Height: _____ Weight: _____ BP: _____ Pulse: _____

1) Eyes: Visual Acuity: Left _____ Right _____ Glasses ☐ Contacts ☐

2) Skin: _____

3) Ears: _____ Hearing Aide ☐

4) Nose: _____ Sinus Disease? _____

5) Mouth/Throat: _____

6) Thyroid: _____

7) Lungs: _____ History of TB? Y ☐ N ☐

(Must complete Tuberculosis Test Form)

8) Hernia: _____

9) Varicose Veins: _____

10) Nervous System: _____

History of Mental or Nervous Disorder? _____

11) Current Medications/OTC drugs, Vitamins: _____

_____

(Attach additional sheet if needed)

12) Please list all medications/things you are allergic to: (i.e. Latex, Food, Dust, etc...) _____

_____

13) Skeletal System: _____

Can applicant lift 50 pounds? Y ☐ N ☐ (Such as would be needed in wheelchair or bed transfers, etc.)

Signature of Examiner: _____

Printed Name: _____

Date of Exam: _____

SURGICORE SURGICAL CENTER, LLC
444 MARKET STREET
SADDLE BROOK, NJ 07663

TEL. (201) 843-9441
FAX (201) 843-9442

REFERENCE FORM

Hello Dr. _____:

You have been requested to provide reference information for Dr. _____, an applicant for admitting privileges to Surgicore Surgical Center, LLC. Pertinent information concerning the applicant will be helpful to the Governing Body of Surgicore Surgical Center, LLC in processing his/her application for privileges.

As one of the applicant's references, you are familiar with his/her professional work and have knowledge of his/her ability, character and reputation. The Board would appreciate information that bears upon the extent of the responsibility borne by the applicant in his/her professional work as well as your opinion of his/her professional competence in his/her medical specialty and moral character.

This form is to be completed by a physician and the recommending physician must have known the applicant for at least six months. Recommending physicians are strongly urged to include additional comments. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included.

The Board appreciates your cooperation in supplying the information requested on the enclosed sheet. Once you have completed the form, please either mail it or fax it back to the address and fax # provided above.

THANK YOU VERY MUCH FOR YOUR VALUABLE TIME!!!!!!!!

PLEASE FAX BACK TO (201) 843-9442

SURGICORE SURGICAL CENTER, LLC

REFERENCE FORM

PLEASE TYPE OR PRINT CLEARLY:

1. NAME OF APPLICANT _____

2. PROFESSIONAL RELATIONSHIP TO APPLICANT _____

_____

_____

3. NUMBER OF YEARS YOU HAVE KNOWN THE APPLICANT _____

4. PLEASE EVALUATE THE APPLICANT IN THE CATEGORIES OF WHICH YOU HAVE PERSONAL KNOWLEDGE:

   a. PROFESSIONAL KNOWLEDGE/COMPETENCE AND EXPERIENCE OBSERVING/WORKING WITH PHYSICIAN:

_____

_____

   b. MORAL CHARACTER WITH RESPECT TO HONESTY, INTEGRITY, AND GENERAL CONDUCT:

_____

_____

5. DO YOU RECOMMEND THE APPLICANT FOR ADMITTING PRIVILEGES TO A SURGERY CENTER?

Yes _____ No _____ If No please attach a detailed written explanation of your reasons for not recommending this applicant.

6. OTHER COMMENTS: _____

_____

(Attach an additional sheet of paper, if you wish to make additional comments)

I hereby certify that the information given above is correct to the best of my knowledge and belief, and opinions expressed above represent my best judgment. I hereby agree to provide further information to the Board if requested to do so.

_____

Name (type or print clearly) Signature

_____

Business Address Date

_____

City/State Zip Code Telephone #

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_____

Name (type or print clearly) Signature

_____

Business Address Date

_____

City/State Zip Code Telephone #