MEDICAL AFFAIRS OFFICE
310 East 14th Street
South Building-Basement, Suite B07
New York, New York 10003
Phone: (212) 979-4664 / 4305
Fax: (212) 353-5950
Email: llevin@nyee.edu

IN ADDITION to the Reappointment Application and forms, current copies of the following documents must be submitted to the Medical Affairs Office via scan/email, mail, and/or fax:

- Updated Curriculum Vitae
- A **clearly identifiable** Government-issued photo ID (i.e. Driver's License, Passport). The photo cannot be faded or blacked out. ****Tip:*** Take a picture of your driver's license or passport with your cell phone and email it to llevin@nyee.edu.
- A copy of your current Primary Malpractice Insurance certificate of insurance naming New York Eye and Ear Infirmary as Certificate Holder, with limits of at least $1,300,000 / $3,900,000.
- A copy of your current Excess Layer Malpractice Coverage Face Sheet. The required limits are $1,000,000 / $3,000,000.
- Current PPD or Quantiferon Gold Test (see attached Health Attestation Evaluation). **If your test results will expire before June 1st, you will need to get a new test.**
- Current Infection Control certificate (if you need to take the course, you may go to www.proceo.com and use the following discount code: **MSH990002121**.
- Copy of Board Certificate, if certified or recertified within the last two years.
- Copies of CME Credit Certificates or website printout. Fifty (50) Category 1 credits are required for Physicians, Dentists, and Physician Assistants earned during the period 2013-2014.
- ACLS/PALS certification (*for Allied Health Professionals and members of the Anesthesiology Department only*).
- Reappointment Fee **for Physicians and Dentists (Active/Affiliate/Courtesy) Only:** A check in the amount of $400.00 (non-refundable) made payable to New York Eye and Ear Infirmary of Mount Sinai *OR* if you wish to pay by credit card, please complete the credit card authorization form at the end of this packet (page 13) **(Does NOT apply to Allied Health Professionals or Consultants)**. **If you are submitting this application after the due date, you must add $500.00 to the initial reappointment fee.**

Reminder: Reappointment to the Professional Staff of New York Eye and Ear Infirmary of Mount Sinai (NYEE) is contingent upon, but not limited to, the following NYEE centered activities:

• Use of Clinical Privileges granted • Number of surgeries as a primary surgeon • Number of surgeries as assisting surgeon • Laser usage (private or service cases) • Patient admissions • Clinical attendance and participation	• Teaching of surgery with Residents • Clinic and inpatient consultations • On-call (especially Metropolitan Eye Trauma Service) • Participation in departmental meetings • Educational/academic endeavors

Please note that your application will NOT BE PROCESSED if you are on suspension for delinquent Medical Records.

Your reappointment application will not be complete until ALL supporting documents are submitted from the above checklist. A late fee of $500 will be assessed if any items are missing.

NEW YORK EYE AND EAR INFIRMARY OF MOUNT SINAI

APPLICATION FOR PROFESSIONAL / ALLIED HEALTH PROFESSIONAL STAFF REAPPOINTMENT

June 1, 2015 to May 31, 2017

ALL FIELDS ARE REQUIRED – IF SOMETHING DOES NOT APPLY, WRITE "N/A"

NAME:____**DEGREE:**__________

DEPARTMENT:_____________________________**SPECIALTY:**_________________________

SUB-SPECIALTY:_________________________________

Home Street Address: ____

Home City/State/Zip Code: ____

Home Phone Number: _____________________ **Cell Phone Number:** ________________________

E-Mail Address for Hospital Communications: ____

Date of Birth: ______________________ **Sex: Male**_____ **Female**_____

Birth City & Birth State/Country: ____

Social Security Number: ____________________________

Marital Status: ________________ **Name of Spouse/Significant Other:** ___________________________

OFFICE INFORMATION

Primary Office Practice Site Location

Office Name: ____ **Tax ID:** _____________________

Street Address: ____ **Suite #:** _________

City/State/Zip Code: ____

Phone 1: __________________ **Phone 2:** ___________________ **Fax:** ____________________

Practicing in Association With: ____

Primary Mailing Address, Fax, and E-mail Address to Receive Business Correspondence

____ **Same as Primary Office Practice Site Information Above**

Street Address: ____

City/State/Zip Code: ____

Phone: ________________ **Fax:** _________________ **E-Mail:** _________________________________

NAME:____

Additional Office Practice Site Location

Office Name: ________________________________ **Tax ID:** ________________

Office Street Address: ________________________________ **Office Suite #:** ________

Office City/State/Zip Code: ____

Office Phone 1: ________________ **Office Fax:** ____________________

Additional Office Practice Site Location

Office Name: ________________________________ **Tax ID:** ________________

Office Street Address: ________________________________ **Office Suite #:** ________

Office City/State/Zip Code: ____

Office Phone 1: ________________ **Office Fax:** ____________________

Additional Office Practice Site Location

Office Name: ________________________________ **Tax ID:** ________________

Office Street Address: ________________________________ **Office Suite #:** ________

Office City/State/Zip Code: ____

Office Phone 1: ________________ **Office Fax:** ____________________

Attach separate sheets if necessary

CONTINUING MEDICAL EDUCATION

It is required that the reappointment application include evidence of your ongoing commitment to Continuing Medical Education. Please submit all pertinent documentation for the past two years, as per the following requirements:

Physicians / Dentists / Physician Assistants = 50

NAME:____

HOSPITAL AFFILIATIONS

Please list your medical staff memberships with other hospitals for the past two years, including affiliations discontinued and the reasons for separation.

Hospital Name:	
Location:	
Start Date:	End Date:
Department:	Department Chair:
Affiliation Status:	
Reason for Discontinuation (if applicable):	
Hospital Name:	
Location:	
Start Date:	End Date:
Department:	Department Chair:
Affiliation Status:	
Reason for Discontinuation (if applicable):	
Hospital Name:	
Location:	
Start Date:	End Date:
Department:	Department Chair:
Affiliation Status:	
Reason for Discontinuation (if applicable):	
Hospital Name:	
Location:	
Start Date:	End Date:
Department:	Department Chair:
Affiliation Status:	
Reason for Discontinuation (if applicable):	
Hospital Name:	
Location:	
Start Date:	End Date:
Department:	Department Chair:
Affiliation Status:	
Reason for Discontinuation (if applicable):	

Attach separate sheets if necessary

NAME:____

BOARD CERTIFICATION

Submit copy of current certificate(s)

Board Specialty/Subspecialty	Year Certified/Recertified	Expiration Date
Primary:		

If not Board Certified, please indicate the following:

Are you in the examination process? Yes_____ No_____

If you answered yes, when are you planning on taking the examination?

Written:_________________ Oral:________________

CLINICAL PRIVILEGES

If you do not have a copy of your current privileges, please contact the Medical Affairs Office at llevin@nyee.edu or (212) 979-4305/4664.

☐ I wish to keep my present privileges without modification.

☐ I request the following additions, deletions or modifications, and I am enclosing an amended clinical delineation of privileges and the reasons for these changes and the documentation of training and/or experience to support my request. ***Please contact the Medical Affairs Office and we will send you a blank form to complete.***

****RADIOLOGISTS and RADIATION ONCOLOGISTS will be required to fill out a new privilege form for the Department of Radiology. Please contact the Medical Affairs Office at llevin@nyee.edu or (212) 979-4305/4661.**

Additions	Deletions
Comments:	

NAME:____

DISCIPLINARY ACTIONS

All Questions Below Must Be Answered.

If you answer "Yes" to any of the questions below, please complete a separate narrative/written response outlining the circumstances for inclusion with your reappointment application.

1. Have **ANY** of the following ever been, or are they currently in the process of being: denied, revoked, suspended, reduced, limited, placed on probation, not renewed, challenged in any way, voluntarily or involuntarily relinquished or under investigation?:

a.	Medical License in any state?	YES ☐	NO ☐
b.	Other Professional Registration/Licenses?	YES ☐	NO ☐
c.	DEA Registration?	YES ☐	NO ☐
d.	Academic Appointment(s)?	YES ☐	NO ☐
e.	Participation in any Residency or Training Program?	YES ☐	NO ☐
f.	Membership on any Hospital or Healthcare Institution Medical Staff?	YES ☐	NO ☐
g.	Clinical Privileges or Other Prerogatives/Rights at any Hospital or Nursing Home?	YES ☐	NO ☐
h.	Other Institutional Affiliation(s) or status?	YES ☐	NO ☐
i.	Board Certifications?	YES ☐	NO ☐
j.	Professional Society Membership(s) or Fellowship(s)?	YES ☐	NO ☐
k.	Office in the Professional Society(ies)	YES ☐	NO ☐
l.	Any other type of Professional Sanctions?	YES ☐	NO ☐
m.	Professional Liability Insurance?	YES ☐	NO ☐
n.	Membership in any IPA, HMO, PHO, PPO managed care organization?	YES ☐	NO ☐
o.	Participation in Medicare, Medicaid or other Governmental Agency?	YES ☐	NO ☐

2.	Since your last NYEE appointment, are any professional misconduct proceedings pending against you or have you ever been found guilty of professional misconduct in this state, or have you been the subject on any report of an incident of professional misconduct as defined by the laws of New York State (Public Health Law 2803-e) or the law of any other state or jurisdiction?	YES ☐	NO ☐
3.	Since your last NYEE appointment, have there been or are there currently pending against you, any malpractice claims, suits, judgments or settlements in this or any other state or jurisdiction?	YES ☐	NO ☐
4.	Are you aware of any information relative to findings against you pertinent to a violation of patient's rights?	YES ☐	NO ☐
5.	Since your last NYEE appointment, have you been convicted of a crime or are there any criminal charges (including misdemeanors) pending against you in this state or any other state?	YES ☐	NO ☐
6.	Do you currently have, or have you ever had any medical and /or psychiatric problems or chemical dependency (legal or illegal) which would adversely affect your ability to treat patients?	YES ☐	NO ☐
7.	Are you currently using or have you ever used illegal drugs or are you engaging or ever have engaged in the unlawful use of legal drugs?	YES ☐	NO ☐
8.	Have you been hospitalized in the past ten years?	YES ☐	NO ☐

NAME:____

ATTESTATION STATEMENT

"In connection with my application for reappointment to the Professional / Allied Health Professional Staff, I request the clinical privileges as indicated on the enclosed Delineation of Privilege Form(s) and I agree to practice only within the scope of privileges granted. I also pledge to provide continuous care for my patients. I understand that unless covered by New York Eye and Ear Infirmary of Mount Sinai (NYEE), I have the responsibility of maintaining and renewing adequate professional liability insurance coverage that satisfies the requirements established by NYEE. I agree to provide NYEE with an updated certificate of insurance on an annual basis or more frequently in the event of any change to my insurance coverage."

"I have read the Bylaws/Rules and Regulations of the Professional Staff of New York Eye and Ear Infirmary of Mount Sinai. I hereby agree to abide by the above and the Administrative Policies and Procedures of NYEE. I further certify that all information submitted by me in this application is complete, true and accurate to the best of my knowledge. Any misstatements in or omissions from this application may constitute cause for denial of reappointment or cause for dismissal from the Professional / Allied Health Professional Staff. To the best of my knowledge my physical and emotional health are satisfactory and there is no basis to believe that the status of my health will impair my ability to deliver proper care to my patients. I agree to limit my practice to the extent necessary if my health status changes. I understand and agree that as an applicant for reappointment, I have the burden of producing adequate information for proper evaluation of my professional competence and other qualifications and/or resolving any doubts about such qualifications."

"I agree to notify the NYEE immediately of any investigation or action by any state or federal agency regarding my professional conduct or practice or any investigation or any curtailment or revocation of privileges at any other hospital or health care institution in any state. I understand that I have an obligation to inform New York Eye and Ear Infirmary of Mount Sinai of any changes in my status or in any information provided in this application during the time of its pendency, and at any time thereafter if granted reappointment to the Professional / Allied Health Professional staff."

____
(PRINT NAME)

________________________________ ________________
(Applicant's Signature) (Date)

New York
Eye and Ear
Infirmary of
Mount
Sinai

CONSENT AND RELEASE FROM LIABILITY

(In compliance with NYS Law)

In signing this form I, ____, hereby:
(Please Print Name)

- Authorize representatives of New York Eye and Ear Infirmary of Mount Sinai to consult with representatives of other health care related facilities with which I am or ever have been associated, and with others who may have information bearing on my competence, character, health status, ethics and other qualifications for staff membership and privileges;
- Consent to the release and inspection by representatives of New York Eye and Ear Infirmary of Mount Sinai of all records and documents that may be material to an evaluation of my competence, character, health status, ethics and other professional qualifications for staff membership and privileges;
- Release from any liability all representatives of New York Eye and Ear Infirmary of Mount Sinai including its Board of Trustees, Infirmary Administration, medical staff and allied health professional staff for their acts performed and statements made in good faith and without malice in connection with evaluating my application, credentials and qualifications for staff membership and privileges, including privileged or otherwise confidential information. Such release to be effective whether or not my application is accepted for professional staff membership;
- Release from any liability all individuals and organizations who provide information to representatives of New York Eye and Ear Infirmary of Mount Sinai in good faith and without malice concerning my competence, character, health status, ethics, and other qualifications for staff membership and clinical privileges, including otherwise privileged of confidential information. Such release to be effective whether or not my application is accepted for professional staff membership;
- Authorize representatives of New York Eye and Ear Infirmary of Mount Sinai including its Board of Trustees, Administration, medical staff and allied health professional staff to provide health care facilities, medical associations, licensing boards and other health care related entities any information relevant to me, including otherwise privileged or confidential information, and release from any liability all representatives of New York Eye and Ear Infirmary of Mount Sinai.
- Agree to appear for interviews in regard to my application for staff privileges at New York Eye and Ear Infirmary of Mount Sinai;
- Agree to execute and deliver such additional documents, including specific releases, and provide such supplementary information as may be necessary or appropriate to carry out the foregoing.

Signature: ______________________________________ **Date:**__________________

Reviewed and Revised: April 2014
January 2005

Signature Page

New York
Eye and Ear
Infirmary of
Mount
Sinai

MEDICARE ACKNOWLEDGEMENT

TO: All Members of the Professional Staff

FROM: J. Robert Rosenthal. M.D., Chief Medical Officer

The Infirmary is mandated to meet certain requirements under Federal and New York State regulations.

The Infirmary MUST have on file a signed acknowledgement from each attending physician that the physician has received and read the following:

I. FOR NON-MEDICARE PAYERS

In accordance with Section 405.20 of Chapter V of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York, I have read and I fully understand the following notice:

"Notice to Physicians: Payment to hospitals for inpatient services is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, and for neonates, upon birth weight or admission weight as well. These data must be documented by the patient's medical record. Anyone who misrepresents, falsifies, or conceals this information may be subject to fine; imprisonment, or civil penalty under applicable Federal and New York State laws."
and

II FOR MEDICARE PAYERS

In accordance with Section 412.46, Subpart C, of the Federal Register (Vol. 50, No. 61), I have read and I fully understand the following notice:

"Notice to Physicians: Medicare (CHAMPUS) payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient: as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment; or civil penalty under applicable Federal and New York State laws."

NO SIGNATURE STAMPS, DO NOT TYPE

____ ____________________

Physician Name (print only) Date

____

Physician Full Legal Signature

Revised 4/2/2014
8/18/2006

Signature Page

MEDICAID PROVIDER REGISTRATION

In accordance with Medicaid Fee-for-Service (FFS) requirements for any sort of prescription (medications, labs, diagnostic tests, PT/OT), physician and hospital FFS reimbursements are contingent upon your registration through the www.emedny.org provider enrollment website.

Even if you do not bill Medicaid directly, hospital charges billed to Medicaid that are linked to you as a care provider require that you be registered. Registering does not require providers to participate in the Medicaid program for their patients.

Under federal law, Medicaid must deny provider and/or hospital claims where ordering / prescribing / referring Attending (OPRA) physicians and other healthcare professionals (e.g., Physician Assistants, Nurse Practitioners) are not enrolled.

Please enroll (or verify your enrollment) at www.emedny.org (click on *Provider Enrollment*).

_____ I am registered with Medicaid

_____ I have submitted my registration with Medicaid and am awaiting confirmation

_____ I chose to not register with Medicaid at this time*

____________________________________ ________________________
Signature Date

____
Print Name

*All providers with hospital admitting/ordering privileges are expected to register with Medicaid as either a billing or non-billing provider. Instances where a provider declines to register will be reviewed by the department chairman and the hospital president.

Signature Page

PENDING AND SETTLED MALPRACTICE CASES

Please provide additional details below if you have been named as a defendant or other party in a malpractice action, or if cases have been settled or ended in a judgment against you. (Please make copies if you need more space).

PRACTITIONER NAME:____

PATIENT'S NAME: ____

Insurance Carrier: ____

Date of Summons: ____

Date of Occurrence: ____

Nature of Claim: ____

Disposition:

[ ] Pending Date:____________

[ ] Settled Amount ($) Date:____________

[ ] Judgment in favor of Physician? Date:____________

[ ] Judgment against Physician? Amount ($) Date:____________

[ ] Discontinued Date___________ Date:____________

[ ] Other_________________________________ Date:____________

PATIENT'S NAME: ____

Insurance Carrier: ____

Date of Summons: ____

Date of Occurrence: ____

Nature of Claim: ____

Disposition:

[ ] Pending Date:____________

[ ] Settled Amount ($) Date:____________

[ ] Judgment in favor of Physician? Date:____________

[ ] Judgment against Physician? Amount ($) Date:____________

[ ] Discontinued Date___________ Date:____________

[ ] Other_________________________________ Date:____________

Practitioner Signature: _______________________________________**Date:** ________________

Revised 4/2/2014, 10/6/2006

Make copies of this page if necessary.

New York Eye and Ear Infirmary of **Mount Sinai**

Health Status Evaluation

____

(Please Print Name)

HOSPITAL POLICY MANDATES THAT THE HEALTH EXAMINATION MAY NOT BE PERFORMED BY A PHYSICAN OR ALLIED HEALTH PROFESSIONAL WHO IS A FIRST DEGREE RELATIVE, SPOUSE, SIGNIFCANT OTHER OR BUSINESS PARTNER.

- This is to certify that to the best of my knowledge the above named applicant is in good health and is mentally and physically competent to carry out his/her responsibilities as a member of the attending staff of New York Eye and Ear Infirmary of Mount Sinai.
- I further certify that I have completed a history and physical examination of the above-named individual, including the following: past history, family history, review of systems, allergies, medications, and habits, and that documentation of same are maintained in a medical record in my office.
- As required by New York State law, I have determined to the best of my ability that the above named individual is free from any apparent health impairment which is potential risk to patients or which might interfere with the performance of his/her duties, including the habituation or addition to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.
  - **Tuberculin Skin Test (PPD):** **Result:** ______________ **(Neg. Ø / Pos.__________mm)**

    Date planted: ______________ **Date read:** ________________

    Lot #:_________________ **Lot Expiration date:** ________________

****THE LOT NUMBER AND LOT EXPIRATION DATE MUST BE COMPLETED****

Note: If Negative; a PPD is required *every year*. If Positive, your physician will be attesting to the absence of any active disease.

- **Quantiferon Gold Test:** **Please attach a copy of the lab report with results.**

Examining physician please note: Any untruthful statement may be grounds for disciplinary action by institutional and licensing authorities.

____

Signature of Examining Physician　　　　Date of Evaluation

____

Print Name

____

Office Address　　　　Office Phone

____

License No.　　　　State

Created 8/18/2006, Revised 4/4/2014, 10/2012

New York
Eye and Ear
Infirmary of
Mount
Sinai

Medical Affairs
310 East 14th Street
New York, New York 10003
Phone (212) 979-4305
Fax (212) 353-5950
Email: medaffairs@nyee.edu

CREDIT CARD PAYMENT FORM

Practitioner Name:____

Address 1: ____

Address 2: ____

City / State / Zip Code: ____

Telephone: ____

Fax: ____

Email: ____

****

I, ____, hereby authorize NEW YORK EYE AND EAR INFIRMARY OF MOUNT SINAI, to charge my credit card account for my Reappointment Application fee of **$400.00**.

CREDIT CARD INFORMATION

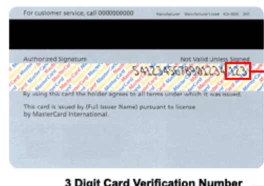
CARD TYPE: VISA______ MasterCard______

CREDIT CARD NUMBER:_______________________________________

CARD HOLDER NAME:____

EXPIRATION DATE:________________

CVV2 or CVC2_____________



Signature:____Date:_____________