MICs Group of Health Services

Matheson – Iroquois Falls – Cochrane

APPLICATION FOR INITIAL APPOINTMENT OF NURSE PRACTITIONER

PART A: IDENTIFYING INFORMATION

Last Name:		**First Name:**	
Home Address:		**City:**	**Province:** / **Postal Code:**
Business Address:		**City:**	**Province:** / **Postal Code:**
Office Phone Listed:	**Home Phone Listed:**	**Home Phone Unlisted:**	**Cell Phone:**
OHIP Billing #:	**W.S.I.B. #:**	**E-mail Address:**	
CNO Membership #:	**CNPS Beneficiary #:**	**Other Coverage – Name of Company and Policy #:**	
Name of Collaborative Physician[1]:		**Collaborative Physician CPSO Registration #:**	

IMPORTANT PLEASE ATTACH A PHOTOCOPY OF YOUR:

- ✓ **Current license to practice**
- ✓ **Proof of Insurance / Liability Protection (CNPS)**
- ✓ **College of Nurses of Ontario Annual Membership Fee (receipt)**

PART B: QUALIFICATIONS

Ontario Licence (Please attach a copy of your CNO Renewal Receipt)

Licensed to Practice in Ontario?	**Type:**	**Date First Issued:** //yy //mm //dd
College Registration #:		**Expiry Date:** //yy //mm //dd

Other Licences

Other/Previous Practice Licenses(s)?	**Province:**	**Country:**	**Type:**
Licence/Registration #:	**Date First Issued:** //yy //mm //dd		**Expiry Date:** //yy //mm //dd

[1] **RNEC applicants – Please attach letter from collaborative physician authorizing relationship as Schedule "E".**

Liability Insurance Information (Please provide proof of insurance.)

CNPS #:	**Class:**
Other Coverage – Name of Company:	**Policy #:**

PART C: EDUCATION AND TRAINING (Please enclose copy of up-to-date curriculum vitae, including record of professional education, post-graduate training, and chronology of academic and professional career, organizational positions and committee membership)

Nursing Education

		Dates	
Name of University, College, Nursing, Medical School	Diploma/Degree	From	To

Nursing Education (Please attach copy of certificate)

		Dates	
Name of University, College, Nursing, Medical School	Diploma/Degree	From	To

Post Graduate Qualifications (Certificates/Fellowships)
(Attach copy of fellowship/certification documentation)

		Dates	
Fellowship/Certificate	Specialty	From	To

Hospital Affiliations (Past and Present)

			Dates	
Name of Hospital/Location	Staff Category	Privileges	From	To

Location and Duration of all Previous Practices

	Dates	
Practice location	From	To

Professional Societies and Associations

PART D: REFERENCES

List below at least three (3) appropriate references including the Chief of Staff of the last hospital where you held privileges or received training; the Service Head or Head of Training Program if enrolled in a Graduate Training Program within the past three years; and the Dean of Medicine/Midwifery/Nursing of the last educational institution in which you held an appointment or were trained (applicable to recent graduates only).

Name & Title of Reference	Full address	Tel. #	Fax #

PART E: DETAILS OF REQUEST FOR APPOINTMENT

Category of Professional Staff Privileges Requested:

☐ Active ☐ Courtesy ☐ Locum Tenens ☐ Consulting

Name of Department/Program/Service/Division to which Appointment Requested:

☐ **Medical Program:**

General Practice ☐ Internal Medicine ☐

Pediatrics ☐ RNEC ☐

PART F: PROFESSIONAL LICENSING, PRIVILEGES AND MEMBERSHIP HISTORY

#	Questions	Yes	No
1.	Has your licence to practice nursing in any jurisdiction ever been denied, suspended, restricted, terminated, curtailed, revoked, resigned (on a voluntary or involuntary basis), or not renewed?		
2.	Have your privileges in any hospital or healthcare institution ever been denied, suspended, restricted, terminated, curtailed, revoked, resigned (on a voluntary or involuntary basis), or not renewed?		
3.	Have your qualifications to practice ever been denied, suspended, restricted, terminated, curtailed, revoked, resigned (on a voluntary or involuntary basis), or not renewed?		
4.	Has any professional academic appointment ever been denied, suspended, restricted, terminated, curtailed, revoked, resigned (on a voluntary or involuntary basis), or not renewed?		

IF THE ANSWER TO ANY OF THE ABOVE FOUR (4) QUESTIONS IS "YES", PROVIDE A STATEMENT OF THE FULL DETAILS. THE STATEMENT MUST INCLUDE:

1. The reasons for the denial, suspension, restriction, termination, curtailment, revocation, resignation (voluntary or involuntary), or non-renewal of your licence, privileges, qualifications to practice, and/or academic appointment
2. The substance of both the allegations and findings in any such action, proceeding, hearing, or procedure involving the denial, suspension, restriction, termination, curtailment, revocation, resignation (voluntary or involuntary), or non-renewal of your licence, privileges, membership, and/or academic appointment
3. The date of the denial, suspension, restriction, termination, curtailment, revocation, resignation (voluntary or involuntary), or non-renewal of your licence, privileges, qualifications to practice, and/or academic appointment, and the name and address of the hospital or other institution with which you were affiliated at the time
4. Any additional information concerning such action, proceedings, hearing, or procedure as you may deem appropriate or relevant.

PART G: DISCIPLINARY HISTORY

#	Questions	Yes	No
1.	Have you ever been subject to disciplinary action by a professional college?		
2.	Are there any professional misconduct proceedings, competency investigations, performance reviews, peer review-type proceedings, or malpractice actions pending wherein you are a party in this province or any other province or country?		
3.	Have any judgments, settlements, findings, decisions, or any other determinations of any kind whatsoever been entered or made in any professional misconduct proceeding, competency investigation, performance review, peer review-type proceeding, or malpractice action related to your medical practice?		

IF THE ANSWER TO ANY OF THE ABOVE THREE (3) QUESTIONS IS "YES", PROVIDE A STATEMENT OF THE FULL DETAILS. THE STATEMENT MUST INCLUDE:

1. The substance of both the allegations and findings in any such proceeding, investigation review or action
2. The manner in which the proceeding, investigation, review or action was resolved (i.e. dismissed, settled, judgment entered, etc.)
3. The date and jurisdiction in which the judgment, settlement, finding, decision, or determination was made
4. Any additional information concerning such proceeding or action as you may deem appropriate or relevant.

PART H: APPLICANT'S LEGAL HISTORY

#	Questions	Yes	No
1.	Have you ever been convicted of a crime or been the subject of a criminal proceeding in any province or country that may impact upon your suitability to be granted the privileges for which you are applying?		
2.	Have you ever been a party to a civil suit related to your medical practice where there was a finding of negligence or battery or where there was an out-of-court settlement, in any province or country?		

IF THE ANSWER TO ANY OF THE ABOVE TWO (2) QUESTIONS IS "YES", PROVIDE A STATEMENT OF THE FULL DETAILS. THE STATEMENT MUST INCLUDE:

1. The substance of the findings in any such criminal proceeding

2. The manner in which the civil action was resolved (i.e. dismissed, settled, judgment entered, etc.) including terms of settlement
3. The date and jurisdiction in which the judgment, settlement, finding, decision, or determination was made
4. Any additional information concerning such criminal or civil action as you may deem appropriate or relevant.

PART I: APPLICANT'S HEALTH HISTORY

#	Questions	Yes	No
1.	Are you being treated or have you ever been treated for any medical condition, impairment, disease or illness (either physical or mental) that may impact on your present ability to practice? If yes, please see section 1.2(n) of the Standardized Credentialing Policy and complete and submit *Schedule A*.		

PART J: APPLICANT'S ACKNOWLEDGEMENT

My making of this application and signature below indicated my understanding of and consent to the following:

1. I fully recognize and agree that any misstatements in, or omissions from, this Application constitutes cause for denial of my appointment and may, at the sole discretion of the Hospital, result in a recommendation being made that my privileges be revoked or suspended or otherwise dealt with in compliance with the *Public Hospitals Act* (Ontario).
2. I acknowledge that I have read and understood the *Public Hospitals Act* (Ontario), Regulation 965 "Hospital Management" passed under the *Public Hospitals Act* (Ontario), the Hospital's By-laws, the rules and regulations, the Hospital's Standardized Credentialing Policy and other Hospital policies and the Canadian Medical Association Code of Ethics, and if I am appointed to the Professional Staff of the Hospital, I agree to govern myself in accordance with the foregoing, as they may be amended from time to time.
3. I acknowledge that if I am appointed to the Professional Staff of the Hospital:
   (i) any failure on my part to provide services to the Hospital in accordance with the legislation, By-laws, rules and regulations referred to in paragraph (2) above will constitute a breach of my obligations, and the Hospital may, upon consideration of the individual circumstances, remove my access to any and all Hospital resources, including limiting or restricting of operating room time, or take such actions as is reasonable, in accordance with the *Public Hospitals Act* (Ontario), the Hospital By-laws and rules and regulations, the Hospital's Standardized Credentialing Policy and other Hospital policies; and

   (ii) the Hospital may refuse to appoint an applicant to the Professional Staff where the applicant refuses to acknowledge his or her responsibility to abide by a commitment to provide services in accordance with the privileges granted by the Board, and in accordance with the *Public Hospitals Act* (Ontario), the Hospital By-laws and rules and regulations, the Hospital's Standardized Credentialing Policy and other Hospital policies.
4. I agree to appear for any meetings, hearings or interviews regarding my Application at my own expense.
5. I authorize the Hospital, its Chief Executive Officer, Chief of Staff, designated members of the Professional Staff and their representatives to contact and consult with administrators, members of professional staffs and other hospitals or institutions with which I have been associated or affiliated, including without limitation those persons listed on this Application as references, and with other individuals and institutions, including past and present malpractice carriers and the College of Nurses of Ontario Canadian who may have information

bearing on my professional competence, character and overall qualifications for the privileges for which I am applying.

6. I consent to the inspection by the Hospital, its Professional Staff and their representatives of all records and documents of any kind or nature, including records, at other hospitals, similar institutions or regulatory bodies that are material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested.

7. I agree to sign the "Authorization and Consent to the Release of Information from Treating Physician" which is annexed as *Schedule A* to this Application, and to continue to assist the Hospital in any way required to secure information regarding my Application and my continuing exercise of clinical privileges and membership on the Professional Staff of the Hospital.

8. I understand and agree that, as an Applicant for Professional Staff membership, I have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.

9. I confirm that I have not requested privileges for any procedures for which I am not qualified. I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe and represent that I am qualified to perform all procedures for which I have requested privileges.

10. I verify that the information provided by me in this Application is true and accurate to the best of my knowledge and belief.

I HAVE BEEN ADVISED OF, AND HEREBY ACKNOWLEDGE, MY OBLIGATION TO ADVISE THE HOSPITAL IN WRITING IMMEDIATELY OF ANY NEW, DIFFERENT OR ADDITIONAL INFORMATION RELEVANT TO ANY OF THE QUESTIONS OR ITEMS OF INFORMATION REQUESTED IN THIS APPLICATION WHICH AT ANY TIME COMES TO MY ATTENTION.

Signature of Applicant

Date

SCHEDULE A

AUTHORIZATION AND CONSENT TO THE RELEASE OF INFORMATION FROM TREATING PHYSICIAN

Name of treating physician/hospital/treatment center: _____

Address: _____

_____

I,_____, an Applicant for appointment to the Professional Staff of the MICs Group of Health Services (Bingham Memorial Hospital, Anson General Hospital, and Lady Minto Hospital) hereby authorize and consent to you, my treating physician, to discuss with a member of the Credentials Committee of the Hospital the following medical condition, impairment, disease or illness (either physical or mental) which I feel may be relevant to my present ability to practice medicine:

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_____

Print Name of Physician Legibly **Signature of Physician**

_____

Date