

**General Application
Clinical Pharmacist Credentials**

Primary practice area: Specialty:
Supervising Physician(s):

Personal Information

Name:
Primary Practice Group or Institution:
Primary Office Address:
Office Telephone:
Pager:
Fax:
Email address:
Home address:
Home Telephone:
Date of Birth:
Social Security Number:
Place of Birth:
Citizenship:
Sex:

Professional/Graduate Education

Name of Institution:
Dates of Attendance:
Mailing Address:
Internet address:
Degree Awarded:
Telephone number:
Fax number:

Post-Graduate Education (repeat notations as many times a necessary)

Institution Name:
Dates of Attendance:
Address
Degree Awarded:
Telephone number:
Fax number:
Internet Address:
Name of current program director:

Professional Career/Work History (repeat notations as many times as necessary)

Affiliation Name:
Department:

Job Title:
Supervisor Name and Title:
Dates of employment:
Address:
Telephone number:
Fax number:
Internet address:

Professional References (peers who directly observe your service; specify number of references)

Reference name:
Address:
Telephone number:
Fax number:
Email address:

Licenses and Registrations

[State] Medical Board Number: (if applicable)
[State] Pharmacy Board Number:
Other states: (mark active or inactive)

Clinical Privileges held with other institutions:

Site:
Privilege:
Effective date/ expiration date:

Certifications (repeat notation as many times as necessary)

Certification name:
Certificate number:
Issue date:
Expiration date:

Drug Enforcement Administration (DEA, if applicable)

Number:
Expiration date:
Currently valid in [state]?

Personal Health Status

1. Have you ever been hospitalized or institutionalized or involved in an outpatient treatment program in the last 5 years?
2. Do you have any physical or mental condition that may limit your ability to participate fully in the care of your patients?
3. Do you have any continuing physical or mental health problems that require ongoing treatment?
4. Do you now or have you ever had a drug or alcohol or psychiatric problem requiring intervention?

Disciplinary Actions

1. Have any of the following been or in the process of being denied, revoked, suspended, relinquished, withdrawn, reduced, placed on probation, not renewed or pending investigation?
 - License or registration in any state
 - Other professional license/registration
 - DEA certificate of registration
 - Academic appointment
 - Membership on any hospital staff
 - Clinical privileges
 - Certification
 - Any other type of professional sanction
2. Have you ever resigned to avoid possible disciplinary action?
3. Have you ever been arrested or convicted of a felony?
4. Have you ever been investigated by a governmental agency?
5. Have you ever been restricted from participation with any governmental insurance agency or private insurance agency?

Professional Liability Insurance

Present Carrier:

Dates of coverage:

Address:

Telephone:

Fax:

Policy number:

Coverage limits:

Internet Address:

Other carriers in the past 5 years:

1. Have you ever had:
 - a. Lawsuit filed against you alleging fraud, liability, or malpractice?
 - b. Settlement paid on your behalf due to a lawsuit alleging fraud, liability or malpractice?
 - c. Judgment rendered against you due to a lawsuit alleging fraud, liability or malpractice?
 - d. Liability or malpractice claim brought against you that was resolved prior to initiation of a lawsuit for an amount of more than \$5000?
2. Has your professional liability insurance ever been denied, cancelled, or have you ever been refused a policy renewal?
3. Does your professional liability insurance policy carry any stated exclusions for specific procedures or treatments?

Statement of Understanding and Agreement

(This statement authorizes the institutional privileging committee to contact any and all persons and institutions on this application to verify the credentials. Also verifies that the applicant is aware of the privileging process and agreement to abide by all institutional rules of conduct. The applicant signs at the end.)

Supervising Physician Statement

(Statement signed by the supervising physician for the clinical pharmacist that this person will act in accordance with rules of the institution for clinical supervisors. Signed by the supervising physician at the end.)

Approval Signatures (as required by the institution)

Other Documents to Provide to Committee (in addition to applications)

Copy of current valid license(s)

Copy of current DEA certificate (if applicable)

Letters of verification from School, Post-graduate training institution, all employers

Letters of reference from peers (see above)

Copy of clinical pharmacist collaborative practice agreement submitted to state board (if applicable)

Official transcripts

Letter from professional liability insurance company on any prior claims experiences

Letters should include the following information:

Verification of time span (if applicable)

Description of training experience or practice

Comment on competency, clinical skills/judgment, and/or character