PLAZA
Medical Center of Fort Worth

Pre-application document checklist-please return all with:

1) Cover letter – "Question 6 response for Covering Physician
2) Pre-application (all questions answered completely
3) Delegate Authorization form
4) Current Health Documentation (Titer/TB/Flu)
5) MRSA Statement
6) Call Coverage Form
7) Current CV
8) Current Photo
9) Application fee ($300 for physicians/$200 for Advance Practice Professionals

PLAZA
Medical Center of Fort Worth

Date: _____

Thank you for your interest in applying for appointment to the Medical Staff at Plaza Medical Center of Ft. Worth.

Applications to the medical staff or advanced practice professionals are being provided to those individuals who meet the requirements listed on the attached sheet. Please be aware that these are base line standards.

1. Currently licensed by the State of Texas.

2. Maintain a Federal DEA (Drug Enforcement Agency) if prescribing scheduled substances and a statement of any restrictions, if applicable. ***NOTE: *Your current Texas office address MUST be listed on your DEA certificate before your application is presented to our Credentials committee for recommendation of privileges.***

3. Carry professional liability insurance coverage in an amount specified by the Plaza Medical Center, Board of Trustees. (Minimum requirement at present is $200,000/600,000.)

4. Satisfactory completion of an approved post-graduate residency training program and/or fellowship, if applicable. (See attached requirements).

5. Board certification or eligibility to obtain board certification within five years of completion of residency training program.

6. Provide the name of a physician practicing in his/her specialty with medical staff privileges at Plaza Medical Center who will provide alternative coverage for his/her patients. (Rules and Regulations and Medical Staff Bylaws requirement)-**_____

7. Established or plan to establish an office and residence within thirty (30) minutes of the hospital to facilitate adequate and continuous patient care.

Please complete the application in its entirety and using the checklist provided below-return it and additional documents within 20 days. Please note: Plaza charges a fee of $300 for any new applicant to the Medical Staff and $200 for Advanced Practice Professionals and must be returned with this document.

The form and documents will be reviewed and if no additional communication is needed, an application packet will be forwarded to you from the HCA Credentialing Processing Center (CPC) in Houston.

If you have any questions or we can be of assistance in any way, please do not hesitate to call (817) 347-5876.

Sincerely,
Medical Staff Office

PLAZA
Medical Center of Fort Worth

PLAZA MEDICAL CENTER OF FORT WORTH

Minimum criteria for any practitioner requesting appointment to the Medical Staff at Plaza Medical Center of Fort Worth is successful completion of an ACGME/AOA approved residency program and/or fellowship program leading to Board Certification. Do not submit this pre-app unless you have completed your training program OR you are within 60 days of completion. The following list shows the minimum acceptable years of training for various specialties. PLEASE CIRCLE ONE.

Advanced Practice Nurse- Name of Sponsor _____	Anesthesiology (Contracted Service)
Cardiology	Cardio-Thoracic
Colon/rectal Surgery	CRNA (Contracted Service)
Dermatology	Emergency Medicine (Contracted Service)
Endocrinology	Family Practice (NMM, OMM)
Gastroenterology	General Surgery
Gynecology	Internal Medicine
Interventional Cardiology	Nephrology
Neurology	Neurosurgery
Obstetrics	Oncology
Ophthalmology	Oral Surgery
Orthopedics	Otolaryngology
Pathology	Physical Medicine
Physician Assistant- Name of Sponsor_____	Plastic Surgery
Podiatry	Psychiatry
Pulmonology	Radiology
Urology	Vascular

PLAZA
Medical Center of Fort Worth

Pre-applications submitted that do not meet the criteria noted above will not be issued an application to the Medical Staff. If the postgraduate training was completed at a time when the number of years required for Board Certification was different than those indicated above, please provide additional explanation. Board Certification is now required within 5 years of completion of training.
Please print legibly:

NAME: _____

INDIVIDUAL NPI: _____ **GROUP NPI:** _____

SOCIAL SECURITY NUMBER: _____ **DATE OF BIRTH:** _____

EMAIL: _____

HOME ADDRESS: _____

HOME PHONE or CELL #: _____

OFFICE ADDRESS: _____
(within 30 minutes if Plaza Medical Center)

OFFICE PHONE #: _____ **OFFICE FAX #:** _____

CREDENTIALING CONTACT: _____

MEDICAL SCHOOL: _____ **DATE OF GRADUATION:** _____

SPECIALTY: _____

NAME OF BOARD: _____ **DATE CERTIFIED:** _____

***DEA NUMBER:** _____ **(your current Texas office address must be listed on your DEA certificate before your application is present to our Credentials committee for recommendation of privileges).**

CATEGORY: _____
Categories: (Active (12 patient contacts per year), Affiliate, Ambulatory)

PLAZA
Medical Center of Fort Worth

List States where licensed and permit number:

STATE	NUMBER	STATE	NUMBER

PROFESSIONAL LICENSES/CONTROLLED SUBSTANCES PERMITS AND CERTIFICATES

1. Have you been denied a professional license by any State licensing board or agency? ___ Yes ___ No
2. Has your license to practice medicine in any State been reduced, suspended, limited, revoked, canceled or otherwise diminished in any manner? ___ Yes ___ No
3. Have you been the subject of any disciplinary action or proceeding by any licensing or regulatory agency or State Board including, but not limited to, reprimands, probation, monitoring, limitation of practice or procedures, or mandatory second opinions? ___ Yes ___ No
4. Are there any pending actions, proceedings or investigations related to your professional license? ___ Yes ___ No

If the answer to any of the above questions is yes, please explain

****

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me and/or my professional competence to give such information to Plaza Medical Center of Fort Worth or authorized representative. A photostatic copy of this authorization shall be as valid as the original.

Signature of Applicant:_____Date:_____

PRINTED NAME:_____

Please return form to:

PLAZA MEDICAL CENTER of Fort Worth
Medical Staff Services
900 8th Avenue * Fort Worth, Texas 76104

HCA Credentialing Online - Provider's Authorization for Delegate

Step 1

The contact information listed below has been pre-populated based on your information in our credentialing system. If changes are needed, please indicate below.

Provider Name:

Provider Phone:

Provider Email (required): _____

NOTE: Provider email must be unique to the provider; it cannot be the same address as a delegate.

Step 2

☐ I do not want to select any delegates at this time. I will personally provide re-credentialing information. _____ *initial and skip to Step 3*

☐ I understand that one delegate for all entities is preferred; however, I have different people handle my credentialing at different entities.

☐ I hereby authorize:

Delegate

name:	
email:	
phone: ( ) -	ext.

(hereinafter, individually referred to as "Delegate") to access the HCA Credentialing Online web portal to enter data and submit documents for the HCA Requests for Considerations (RFC) and HCA Reappointment Requests for Information (RRFCs) requests on my behalf. I understand that I will need to review the data and documents and attest to their accuracy before I submit them to HCA via the HCA Credentialing Online web portal.

I acknowledge that I have voluntarily provided the above information, and I have carefully read and understand this Authorization. I understand and agree that a facsimile or photocopy of this Authorization shall be as effective as the original.

_____ PROVIDER SIGNATURE

_____ NAME

_____ SOCIAL SECURITY NUMBER or NPI

_____ DATE (MM/DD/YYYY)

Step 3

Please complete, sign and date. The form may be returned via:

1. Scanned and e-mailed to email below
2. Faxed to the attention of the Intake Team at the fax below or
3. U.S. mail to the address below

Shared Services Center - Houston
8101 W. Sam Houston Parkway South, Houston, TX 77072
Phone: 713-448-2940 Toll-Free: 866-579-0803 Fax: 866-862-5432
Email: HRSCHoustonCPC@hcahealthcare.com

PLAZA
Medical Center of Fort Worth

MRSA STATEMENT/ACKNOWLEDGEMENT

Signatures within this document represent review and acceptance that the MRSA nasal screening protocol will be implemented for the patient populations defined below:

- Patients admitted/transferred from Nursing home, Long Term Care Facility, Other Healthcare Facility (Rehab and Assisted Living Facility), Other Hospital, Jail/Prison or Homeless Shelter
- Patients undergoing total hip, total knee, open spine, and CABG procedures
- Patients with a history of MRSA (defined as a positive nasal swab within the last 365 days) may be placed directly into isolation with a nasal screen
- Dialysis patients, patients with open wounds

_____ _____

Physician Signature Date

_____

Printed Name

PLAZA MEDICAL CENTER

PLAZA
Medical Center of Fort Worth
There Is A Difference

Instructions to Provider:

1. **PRINT/SIGN YOUR NAME AT THE BOTTOM; PLEASE FORWARD THIS FORM TO THE PHYSICIAN WHO WILL COVER YOUR PATIENTS IN YOUR ABSENCE.**
2. THE PHYSICIAN MUST HAVE OR IS APPLYING FOR CURRENT PRIVILEGES AT Plaza Medical Center of Fort Worth.

CALL COVERAGE

Below you will find the excerpt from the Medical Staff Bylaws regarding coverage requirements at Plaza Medical Center of Fort Worth:

BASIC OBLIGATIONS ACCOMPANYING STAFF APPOINTMENT AND/OR THE GRANTING OF CLINICAL PRIVILEGES
By submitting an application for Staff membership and/or a request for clinical privileges, the applicant signifies agreement to fulfill the following obligations of holding Staff membership and/or clinical privileges. The applicant shall agree to:

2.2.6 *Be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of inpatients and Emergency Department patients in a prompt, efficient, and conscientious manner. ("Appropriate coverage" means coverage by another member of the Medical Staff with specialty-specific privileges equivalent to the Practitioner for whom he or she is providing coverage.)[1] Compliance with this eligibility requirement means that the Practitioner must document that he or she is willing and able to:*

Please complete this section including your covering physicians name and signature and return via fax to: 817-347-5793. Thank you!

Applicant name (Please Print)	Signature
I agreed to provide coverage for his / her patients during any absences.	
Name of covering physician (Please Print)	Specialty of covering physician
Signature of physician agreeing to cover	Date

Please return the completed form to Plaza Medical Center of Fort Worth, Medical Staff Service
by fax to 817-347-5793
or by email to tammy.landry@hcahealthcare.com

Thank you!

Medical Staff Services
Plaza Medical Center of Fort Worth

---

[1] EMTALA

HCA | credentialing online

MEMO

Announcing Online Credentialing!!!

We are pleased to announce a new credentialing process!! The new process will provide you the capability to submit your credentialing requests electronically for all HCA hospitals with the HCA Credentialing Online (HCO) tool.

The HCO tool will take the manual paperwork and data entry credentialing processes and transform them into an easy to use electronic process.

HCO Benefits

- Allow you to submit 1 credentialing request for all HCA hospitals
- Provide you with electronic access to create, modify, and submit your credentialing documents
- Electronic credentialing processes will ensure accuracy and completeness of your data being considered

HCO Features

- Ability to establish a delegate to prepare the required forms and documentation for your approval
- Accessible to all providers having association to or seeking association to our facility
- Online attestation form completion

Learning about HCO and how to use it

- You will receive an email notification when it is time for you or your delegate to complete your initial appointment or re-appointment packet which will provide you a link to job aids, instructions and training materials. If you would like to see this information before it is time for you to complete the forms you can do so by logging onto www.hcacredentialingonline.com

Action Needed!

To ensure you have capability to receive and submit information online through the HCA Credentialing Online system, please complete and return the attached form notifying us that you will provide credentialing information personally or through a delegate.

Please complete the attached authorization form and return in 14 days to the fax number or mailing address indicated in Step 3. If you have any questions please contact our call center at 866-579-0803

Shared Services Center - Houston
8101 W. Sam Houston Parkway South, Houston, TX 77072
Phone: 713-448-2940 Toll-Free: 866-579-0803 Fax: 866-862-5432
Email: HRSCHoustonCPC@hcahealthcare.com