ST. THOMAS EAST END MEDICAL CENTER CORPORATION
PROVIDER INITIAL / RE-CREDENTIALING APPLICATION

4605 Tutu Park Mall, Suite 207
P.O. Box 503177
St. Thomas, VI 00805-3177
Tel: (340)775-3700 * Fax: (340)777-7927
"Your Health is our First Priority"

St. Thomas East End Medical Center Corporation
Initial / Re-credentialing Application
Instructions

Prior to completing this initial application, please read, and observe the following:

1. Modification to the language or format of the St. Thomas East End Medical Center Corporation (STEEMCC) Provider Credentialing/Re-credentialing Application will invalidate the application.
2. Complete the application in its entirety. Keep an unsigned and undated copy of the application on file for future requests. When a request is placed, send a copy of the completed application to STEEMCC, making sure that all the information consider accurate, current, and complete.
3. Please sign and date page 8, Attestation Questions and page 9, Authorization and Release Information Form (*and Attachment A, Professional Liability Action Detail, if applicable*).
4. Each page of the application requires the applicant's initials and the date on which the application was last reviewed.
5. Attach copies of the documents requested each time the application is submitted.
6. If a section does not apply to you, please check the "Does Not Apply" box at the top of the section.
7. Submit application to STEEMCC's Credentialing Department.

Additional Information Needed to be Submitted with this Form

- Current VI Professional License(s) (i.e. MD, DDS, PA, RN, etc.)
- DEA License or CSR Certificate
- ECFMG (*if applicable*)
- Face Sheet of Professional Liability Policy or Certificate *(if applicable)*
- Immunizations (Hep B and flu shot) and PPD status
- 50 CMEs per last 2 years as required for VI Licensure (Physicians)
- 40 CMEs per last 2 years as required for VI Licensure (Dentist)
- Basic Life Support (for all clinical personnel)
- Proof of Specialty Board Re-Certification
- Current CV
- Supporting Documentation for any additional privileges requested Board Qualification Letter or Board Certification, etc.
- Photo ID
- Certificate of Medical Examination
- Delineation of Privileges
- Current Malpractice Insurance Certificate
- Current Health Certificate on Approved Virgin Islands Government Form

Note: After a provider is initially credentialed, he/she will be recredentialed every two (2) years.

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Acronyms and Definitions

Acronym	Definition	Acronym	Definition
AANA	American Association of Nurse Anesthetist	ID	Identification
ACLS	Advanced Cardiac Life Support	IPA	Independent Practice Association
ATLS	Advanced Trauma Life Support	MD	Doctor of Medicine
BLS	Basic Life Support	NPI	National Provider Identifier
CME	Continuing Medical Education	NRP	Neonatal Resuscitation
CSR	Controlled Substance Registration	PA	Physician's Assistant
CV	Curriculum Vitae	PALS	Pediatric Life Support
DDS	Doctor of Dental Surgery	PHO	Physician Hospital Organization
DEA	Drug Enforcement Administration	PPO	Preferred Provider Organization
ECFMG	Education Commission for Foreign Medical Graduate	RN	Registered Nurse
EXT	Extension	SSN	Social Security Number
HMO	Health Maintenance Organization	STEEMCC	St. Thomas East End Medical Center Corporation

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I. PRACTITIONER INFORMATION				*Please provide the practitioner's full legal name*
Last Name (include suffix: Jr., Sr., III, etc.)	First:		Middle:	Degree(s):
Are there any other names under which you have been known or have used since starting professional training?			☐ YES	☐ NO
Birthdate MM/DD/YYYY:	Birthplace:	Citizenship:	SSN:	Gender: ☐ Male ☐ Female
Immigrant Visa Number (if applicable):		Visa Expiration Date:		Type:
Home Telephone Number:		Mobile/ Alternate Number:		Email Address:

Home Street Address:	City:	State:
	Country:	Zip Code:
Mailing Address:	City:	State:
	Country:	Zip Code:

II. SPECIALTY INFORMATION	*Information may be included in directory listings.*
Principal Clinical Specialty:	Additional Clinical Practice Specialties:

Category of professional activity, check all boxes that apply:
Clinical Practice: Other Professional Activities

☐ Full Time	☐ Part -Time	☐ Administration	☐ Teaching
☐ Locum/ Temporary	☐ Telemedicine	☐ Research	☐ Retired
☐ Other: _____		☐ Other: _____	

III. BOARD CERTIFICATION/ RECERTIFICATION

☐ Does not apply

List all current and part certifications. Please attach additional sheets, if necessary.

Name and address of issuing board	Specialty	Date Certified/ Recertified (MM/YYYY)	Expiration Date (if any) (MM/YYYY)

If not currently board certified, describe your intent for certification, if any, and dates of previous testing and/ or intended future testing for certification below. Please attach additional sheets, if necessary.

IV. OTHER CERTIFICATION

☐ Does not apply

Please attach copy of certificate(s), if applicable

Examples include: ACLS, BLS, ATLS, PALS, NRP, AANA, Fluoroscopy, Radiography, etc.

Type	Number	Certification (MM/YYYY)	Expiration Date (MM/YYYY)

V. PRACTICE AND EMPLOYMENT INFORMATION

Name of Primary Care Practice/ Affiliation or Clinic:		Department Name (if hospital based):	
Primary Telephone Number: Ext:	Primary Fax Number:	Patient Appointment Telephone Number:	Ext:
Primary Clinical Practice Street Address:		Effective Date at Location (MM/YYYY):	
City:	County:	State:	Zip Code:
Mailing / Billing Address:			
City:	County:	State:	Zip Code:
Office Manager:	Officer Manager's Telephone Number	Ext:	Office Manager's Fax Number
Exchange / Answering Service Number Ext:		Page Number:	Office Email Address:
Initial / Recredentialing contact and address (if different from above):			
Initial / Recredentialing Contact's Telephone Number: Ext:	Initial / Recredentialing Contact's Fax Number:	Ext:	Initial / Recredentialing Contact's Email Address:
Federal Tax ID Number or Social Security Number (if used for business purposes):		Name Affiliated with Tax ID Number:	
Name of Primary Care Practice / Affiliation or Clinic:		Department Name (if hospital based):	
Primary Telephone Number: Ext:	Primary Fax Number:	Patient Appointment Telephone Number: Ext:	
Primary Clinical Practice Street Address:		Effective Date at Location (MM/YYYY):	

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City:	County:	State:	Zip Code:
Mailing / Billing Address:			
City:	County:	State:	Zip Code:
Office Manager:	Officer Manager's Telephone Number: Ext:		Office Manager's Fax Number:
Exchange / Answering Service Number: Ext:		Page Number:	Office Email Address:
Initial / Re-credentialing contact and address (if different from above):			
Initial / Recredentialing Contact's Telephone number: Ext:	Initial / Re-credentialing Contact's Fax Number: Ext:		Initial / Re-credentialing Contact's Email Address:
Federal Tax ID Number or Social Security Number (if used for business purposes):		Name Affiliated with Tax ID Number:	
Please list other office locations with above information on a separate sheet.			

VI. ADDITIONAL EDUCATION

☐ Does not apply

If you have completed additional residencies, internships, or advanced specialized education within the past two (2) years, please provide the following information. Please attach additional sheets, if necessary.

Program Name:	Street Address of Program:	
City:	State:	Zip Code:
Specialty:	Phone Number:	Fax Number (if applicable):
From (MM/YYYY):	To (MM/YYYY):	Completion Date (MM/YYYY):
Did you complete the program? ☐ Yes ☐ No (If you did not complete the program, please explain on a separate sheet.)		

VII. CONTINUING MEDICAL EDUCATION

☐ Does not apply

Please list activities for which you have received CME credit(s) during the past two (2) years
Please attach a separate sheet, if needed.

Name	(MM/YYYY) Attended	Hours

VIII. HEALTH CARE LICENSURE, REGISTRATIONS, CERTIFICATES, AND ID NUMBERS

Please attach additional sheets, if necessary.

VI License or Registration Number:	Type:	Expiration Date (MM/DD/YYYY):
Drug Enforcement Administration (DEA) Number:		Expiration Date (MM/DD/YYYY):
Controlled Substance Registration (CSR):		Issued Date (MM/DD/YYYY):
Individual NPI Number:	Medicare Number:	
Full Name and VI License Number Physician Supervising Physician Assistant:		

IX. OTHER STATE HEALTHCARE LICENSES, REGISTRATIONS, AND CERTIFICATES

☐ Does not apply

Please attach additional sheets, if necessary

State / Country:	Number:	Type:
Year Obtained:	Expiration Date (MM/DD/YYYY):	Year Relinquished:
Reason:		
State / Country:	Number:	Type:
Year Obtained:	Expiration Date (MM/DD/YYYY):	Year Relinquished:
Reason:		
State / Country:	Number:	Type:
Year Obtained:	Expiration Date (MM/DD/YYYY):	Year Relinquished:
Reason:		

X. HOSPITAL AND OTHER HEALTHCARE FACILITY AFFILIATIONS

Please list for the past two (2) years all health care institutions where you have and/or had clinical privileges and/or staff membership. Include all (A) affiliations in the past two (2) years, and/or B application in process (*i.e. hospitals, surgery centers, or any other health care facility*). If more space is needed, please attach additional sheets. Do not list residences, internships, of fellowships. Please list employment in Section XI, Professional Practice/ Work History.

A. AFFILIATION IN THE PAST (2) YEARS

Facility Name:	Phone Number:	Fax Number, if available:	Appointment Date (MM/DD/YYYY):	
Street Address:		City:	State:	Zip Code:
Status ☐ Active ☐ Allied Health ☐ Courtesy ☐ Provisional ☐ Other _____				
Facility Name:	Phone Number:	Fax Number, if available:	Appointment Date (MM/DD/YYYY):	
Street Address:		City:	State:	Zip Code:
Status ☐ Active ☐ Allied Health ☐ Courtesy ☐ Provisional ☐ Other _____				
Facility Name:	Phone Number:	Fax Number, If available:	Appointment Date (MM/DD/YYYY):	
Street Address:		City:	State:	Zip Code:
Status ☐ Active ☐ Allied Health ☐ Courtesy ☐ Provisional ☐ Other _____				

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B. APPLICATION IN PROCESS			☐ Does not apply	
Facility Name:	Phone Number:	Fax Number, if available:	Appointment Date (MM/DD/YYYY):	
Street Address:		City:	State:	Zip Code:
Status ☐ Active ☐ Allied Health ☐ Courtesy ☐ Provisional ☐ Other ______				
Facility Name:	Phone Number:	Fax Number, if available:	Appointment Date (MM/DD/YYYY):	
Street Address:		City:	State:	Zip Code:
Status ☐ Active ☐ Allied Health ☐ Courtesy ☐ Provisional ☐ Other ______				
Facility Name:	Phone Number:	Fax Number, if available:	Appointment Date (MM/DD/YYYY):	
Street Address:		City:	State:	Zip Code:
Status ☐ Active ☐ Allied Health ☐ Courtesy ☐ Provisional ☐ Other ______				

XI. PROFESSIONAL PRACTICE/ WORK HISTORY

A. Please list all professional practice/ work history for the past two (2) years.

Name of Current Practice/ Employer:		Contact Name:		
Telephone Number: Ext:	Fax Number:	From (MM/YYYY):	To (MM/YYYY):	
Street Address:		City:	State:	Zip Code:
Contact's Email Address, if available:			Professional Liability Carrier:	
Name of Current Practice/ Employer:		Contact Name:		
Telephone Number: Ext:	Fax Number:	From (MM/YYYY):	To (MM/YYYY):	
Street Address:		City:	State:	Zip Code:
Contact's Email Address, if available:			Professional Liability Carrier:	
Name of Current Practice/ Employer:		Contact Name:		
Telephone Number: Ext:	Fax Number:	From (MM/YYYY):	To (MM/YYYY):	
Street Address:		City:	State:	Zip Code:
Contact's Email Address, if available:			Professional Liability Carrier:	

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Name of Current Practice/ Employer:		Contact Name:		
Telephone Number: Ext:	Fax Number:	From (MM/YYYY):	To (MM/YYYY):	
Street Address:		City:	State:	Zip Code:
Contact's Email Address, if available:			Professional Liability Carrier:	
Name of Current Practice / Employer:		Contact Name:		
Telephone Number: Ext:	Fax Number:	From (MM/YYYY):	To (MM/YYYY):	
Street Address:		City:	State:	Zip Code:
Contact's Email Address, if available:			Professional Liability Carrier:	
Name of Current Practice/ Employer:		Contact Name:		
Telephone Number: Ext:	Fax Number:	From (MM/YYYY):	To (MM/YYYY):	
Street Address:		City:	State:	Zip Code:
Contact's Email Address, if available:			Professional Liability Carrier:	

B. Please explain any gaps greater than two (2) month in the past two (2) years. Include activities and / or names and dates where applicable. Please attach additional sheets, if necessary.

Activities and/or Names	From (MM/YYYY):	To (MM/YYYY):

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XII. PEER REFERENCES

Please list three (3) references from peers

Name of Reference:	Specialty:	Professional Relationship:	
Telephone Number: Ext:	Fax Number:	Email Address, if available:	
Street Address:	City:	State:	Zip Code:
Name of Current Practice / Employer:	Contact Name:		
Telephone Number: Ext:	Fax Number:	From (MM/YYYY):	To (MM/YYYY):
Street Address:	City:	State:	Zip Code:
Name of Reference:	Specialty:	Professional Relationship:	
Telephone Number: Ext:	Fax Number:	Email Address, if available:	
Street Address:	City:	State:	Zip Code:
Name of Current Practice / Employer:	Contact Name:		
Telephone Number: Ext:	Fax Number:	From (MM/YYYY):	To (MM/YYYY):
Street Address:	City:	State:	Zip Code:
Name of Reference:	Specialty:	Professional Relationship:	
Telephone Number: Ext:	Fax Number:	Email Address, if available:	
Street Address:	City:	State:	Zip Code:
Name of Current Practice / Employer:	Contact Name:		
Telephone Number: Ext:	Fax Number:	From (MM/YYYY):	To (MM/YYYY):
Street Address:	City:	State:	Zip Code:

XIII. PROFESSIONAL LIABILITY INSURANCE

Current insurance carrier / provider of professional liability coverage:		Policy Number:	Type of coverage (Check one): ☐ Claims Made ☐ Occurrence	
Name of Local Contact:	Contact's Telephone Number: Ext:	Fax Number	Per Claim of liability:	
Per Claim limit of Liability:	Aggregate Amount	Effective Date (MM/DD/YYYY)	Retroactive Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)
Please list all previous professional liability carriers within the past three (3) years Please attach all additional sheets, if necessary.				☐ Does not apply
Current insurance carrier/ provider of professional liability coverage:		Policy Number:	Type of coverage (Check one): ☐ Claims Made ☐ Occurrence	
Name of Local Contact:	Contact's Telephone Number: Ext:	Fax Number:	Per Claim of liability:	
Per Claim limit of Liability:	Aggregate Amount:	Effective Date: (MM/DD/YYYY)	Retroactive Date: (MM/DD/YYYY)	Expiration Date: (MM/DD/YYYY)
Please list all previous professional liability carriers within the past three (3) years Please attach all additional sheets, if necessary.				☐ Does not apply
Current insurance carrier/ provider of professional liability coverage:		Policy Number:	Type of coverage (Check one): ☐ Claims Made ☐ Occurrence	
Name of Local Contact:	Contact's Telephone Number: Ext:	Fax Number:	Per Claim of liability:	
Per Claim limit of Liability:	Aggregate Amount:	Effective Date: (MM/DD/YYYY)	Retroactive Date: (MM/DD/YYYY)	Expiration Date: (MM/DD/YYYY)
Please list all previous professional liability carriers within the past three (3) years Please attach all additional sheets, if necessary.				☐ Does not apply
Current insurance carrier/ provider of professional liability coverage:		Policy Number:	Type of Coverage (Check one): ☐ Claims Made ☐ Occurrence	
Name of Local Contact:	Contact's Telephone Number: Ext:	Fax Number:	Per Claim of liability:	
Per Claim limit of Liability:	Aggregate Amount:	Effective Date: (MM/DD/YYYY)	Retroactive Date: (MM/DD/YYYY)	Expiration Date: (MM/DD/YYYY)
Please list all previous professional liability carriers within the past three (3) years Please attach all additional sheets, if necessary.				☐ Does not apply

XIV. ATTESTATION QUESTIONS

These questions are to be completed by the Practitioner. Modification to the language or format of these attestation question(s) will invalidate the application.

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet. Please sign and date each additional sheet.

A. **In the last two (2) years** has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/ certificate in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you ever been fined or received a letter of reprimand or is any such action pending or under review?	☐ Yes ☐ No	
B. **In the last two (2) years** have you ever been suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	☐ Yes ☐ No	
C. **In the past two (2) years** have your ever been denied clinical privileges, membership, or contractual participation, by any health care related organization*, or have clinical privileges, membership, participation, or employment at any such organization ever been placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or renewed, or is any such action pending or under review?	☐ Yes ☐ No	
D. **In the last two (2) years** have you ever surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization* while under investigation or potential review?	☐ Yes ☐ No	
E. **In the last two (2) years** has an application for clinical privileges, appointment, membership, employment, or participation in any health care related organization* ever been withdrawn on your request prior to the organization's final action?	☐ Yes ☐ No	
F. **In the last two (2) years** has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	☐ Yes ☐ No	
G. **In the past two (2) years**, have you ever voluntarily or involuntarily left or been discharged from	☐ Yes ☐ No	

medical school or subsequent training programs?		
H. **In the last two (2) years** have you ever had board certification revoked?	☐ Yes ☐ No	
I. **In the last two (2) years** have you ever been the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	☐ Yes ☐ No	
J. **In the last three (2) years** have you ever been charged with a criminal violation (felony or misdemeanor)?	☐ Yes ☐ No	
K. Do you presently use any illegal drugs?	☐ Yes ☐ No	
L. Do you now have, or have you had, any physical condition, mental health condition, or chemical dependency condition (*alcohol or other substance*) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested? If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	☐ Yes ☐ No	
M. Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	☐ Yes ☐ No	
N. **In the last five (5) years** have any professional liability claims or lawsuits ever **been** closed and/or filed against you? If yes, please complete **Attachment A, Professional Liability Action Detail**, for **each** past or current claim and/or lawsuit.	☐ Yes ☐ No	
O. **In the last two (2) years** has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?	☐ Yes ☐ No	

*Example: hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership, or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature:_____Date:_____

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Modified Releases Will Not Be Accepted

By submitting this application, I understand and agree to the following:

1. I understand and acknowledge that, as an applicant for becoming a provider at the St. Thomas East End Medical Center Corporation (STEEMCC) as indicated on this application, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, (if requested). I have disclosed and explained any past or pending professional corrective action, licensure limitation(s) or related matter, if any. I have reported my malpractice claims history (if any) and have attached or will provide a copy of a current certificate of professional liability coverage.
2. I further understand and acknowledge that the health care related organization(s) or designated agent would investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of STEEMCC and related organization(s) as a part of the verification and credentialing/re-credentialing process.
3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated health care related organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.
7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations, and policies.
8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the health care related organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release all supportive documentation regarding this application.

I grant permission for the release of the credentials information contained in this provider application to the following health care related organization(s):

Modification to the language or format of the St. Thomas East End Medical Center Corporation's Initial/ Re-credentialing Application will invalidate the application.

Print Name:_____

Signature:_____Date:_____

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ATTACHMENT A

PROFESSIONAL LIABILITY ACTION DETAIL	**CONFIDENTIAL**
Please list any past or current professional liability action.	
Provider's Name:	
Date of the incident and clinical details (MM/DD/YYYY):	
Your role(s) and specific responsibilities in the incident:	
Subsequent Events:	
Date the suit or claim was filed (MM/DD/YYYY):	
Name and address of insurance carrier/ professional liability provider that handled the claim:	
Your status in the legal action ☐ Primary Defendant ☐ Co-defendant ☐ Other:_____	
Current status of suit or other action:	
Date of settlement, judgement, or dismissal (MM/DD/YYYY):	
If case was settled out of court, or with a judgement, settlement amount attributed to you:	
I verify the information contained in this form is correct and complete to the best of my knowledge.	
Signature:	Date: