

Thank you for your interest in joining our family. Our credentialing specialists are standing by to help fast track the process, so please contact them directly.

Cindy Bleier 859 335 9041.ext. 212, cbleier@mesaer.com

Mandi Bockelman 859 335 9041 ext. 218, abockelman@mesaer.com

Marshall Emergency Physicians is a group of smart, dynamic young physicians running hospital ER's with volumes ranging from 6,000 - 34,000 visits annually in small and medium sized cities. Working hard, playing hard. Hanging together and hanging tough. Taking care of business. And taking care of our own.

We're not corporate suits. We're practitioners of medicine. We know what it takes to work out on the front line because we do it every day. So we're uniquely qualified to take care of the people who do it. (For example, we cap the number of patients our ER physicians see in an hour. So crises aside, they never have to suffer the miseries of an over-scheduled shift. This is a practice, not a factory.)

What makes us truly special is the medical professional-friendly dynamic that drives us. We all want what you want. Work time that challenges and satisfies us. And play time we can fill with the people and pursuits that fulfill us.

Of course we'll match anyone on competitive compensation, flexible full or part time schedules, malpractice and tail coverage, incentives, benefits – the whole ball of wax.

Of course we'll give you every opportunity to make as much money as you want.

And, because we applaud and reward ambition, we'll go a step further. In our group, there's plenty of sky for those who want to fly further, including ER Medical Directorships and administrative positions of considerable responsibility.

We look forward to personally welcoming you to our family.

John Mullins, MD Jimmy Foster, MD

front line medicine

3205 Summit Square Suite 100
Lexington, KY 40509
Phone 859.335.9041
www.mesaER.com

Demographics & General Information

Full Name: _____

Social Security #: _____ Date of Birth: _____

Home address: _____

Home Phone: _____ Cell Phone: _____

Office Phone: _____ Fax: _____

Pager or Other Phone: _____

Email Address: _____

What is the BEST way to reach you?: _____

Place of Birth: (City, State, Country) _____

Citizenship: _____ If not US citizen, status of visa: _____

Marital Status: _____ Name of Spouse: _____

How would you prefer to receive your hospital applications when they are ready?

(You will need to sign the applications, complete privilege request forms, and return all originals to the MESA office.)

Mail (postal) Email In person at the MESA office

Do you currently have an account with **KASPER** (Kentucky All Schedule Prescription Electronic Reporting)?

Yes No

Checklist of Credentialing Documentation - Physicians

Please send copies of the following documents:

Missing items will cause delays in your credentialing.

- | | |
|---|--|
| <input type="checkbox"/> Current Medical License | <input type="checkbox"/> Recent Photograph (preferably an original or digital photo) |
| <input type="checkbox"/> Current ACLS | <input type="checkbox"/> Previous 10 years of malpractice insurance policy numbers (or COI's) |
| <input type="checkbox"/> Current ATLS | <input type="checkbox"/> RESIDENTS: Letter from your residency director granting you permission to moonlight and to participate in the Medicaid program - must include dates of residency |
| <input type="checkbox"/> Current TB Skin Test (within past 12 months), or MESA Positive TB Form | <input type="checkbox"/> Current DEA Certificate |
| <input type="checkbox"/> CV (must be up-to-date) | <input type="checkbox"/> Current PALS |
| <input type="checkbox"/> Medical School Diploma and ECFMG if applicable | <input type="checkbox"/> Current BLS (if applicable) |
| <input type="checkbox"/> Medical Training Certificates (Internship, Residency, Fellowship) | <input type="checkbox"/> Social Security Card |
| <input type="checkbox"/> Birth Certificate or Passport | <input type="checkbox"/> Board Certification (if applicable) |
| <input type="checkbox"/> Drivers License | |
| <input type="checkbox"/> NPI Confirmation Letter/Email from NPPES | |
| <input type="checkbox"/> CME's for the past 3 years (detailed list or individual certificates) | |

Disclosure Questions

If you answer "YES" to any of the following questions, please explain in detail on a separate sheet.

		Yes	No
1	Has your professional liability insurance been terminated by action of the insurance company?		
2	Have you been denied professional liability insurance coverage or been rated at a higher than average risk class for your specialty?		
3	Has your present professional liability insurance carrier excluded any specific procedures from your coverage?		
4	Have any professional liability suits or claims been filed against you?		
5	Have any professional liability suits or claims been filed against you which are presently pending?		
6	Have any judgments or settlements been made against you in professional liability cases?		
7	Have you ever been examined by a specialty board but failed to pass the exam?		
8	Are there any actions that have been initiated or are any pending against you by any state licensing board?		
9	Have you had any professional license or certification in any state that has ever been denied, limited, suspended, sanctioned, revoked, probated, voluntarily or involuntarily relinquished or not renewed?		
10	Have you ever received notice of a proposed or actual exclusion (suspension, sanction, otherwise restricted) from any private health care program(s) or any health care program(s) funded in whole or in part by the state or federal government, including Medicare or Medicaid?		
11	Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program?		
12	Have your narcotics registration certificates ever been limited, suspended, revoked, voluntarily or involuntarily surrendered or not renewed?		
13	If applicable, is your federal and/or state narcotics registration certificate being challenged?		
14	Have you been named as a defendant or convicted of a felony or misdemeanor?		
15	Have your employment, medical staff appointment or clinical privileges ever been voluntarily or involuntarily denied, suspended, diminished, revoked, limited or not renewed at any health care facility?		
16	Have you ever withdrawn your application for appointment, reappointment, clinical privileges, or resigned from the medical staff of any health care facility before a decision was made by its governing board?		
17	Have you ever been the subject of disciplinary proceedings or a focus review based on inappropriate quality of care at any hospital or health care facility?		
18	Have you ever been denied membership or renewal thereof, or been subject to disciplinary or adverse action in any medical or professional organization?		
19	Do you currently have, or have you ever had, any physical, mental, or emotional condition which impaired, or might reasonably be considered to impair, your clinical judgment and/or performance?		
20	Have you ever been admitted to any hospital or been involved in a treatment program for any physical, mental or emotional condition which impaired, or might reasonably be considered to impair, your clinical judgment and/or performance?		
21	Do you currently have, or have you ever had, a dependency on or abuse of the use of alcohol or drugs, or are you currently or have ever been involved in a treatment program for a dependency on or abuse of alcohol or drugs which impaired, or might reasonably be considered to impair, your clinical judgment and/or performance?		

Insurance Credentialing Information

Name: _____

Address: _____

Place of birth (city and state): _____

Do you have Medicare #: Yes No If yes, please provide number: _____

Do you have KY Medicaid #: Yes No If yes, please provide number: _____

If you do not know your Medicaid # please sign the attached letter.
Medicaid requires an original signature.

Do you have any other Medicaid #'s?: Yes No If yes, please provide the State and # in the space below:

There may be times that we will need additional signature; we will send the request to your home with a return envelope. I look forward to working with you.

Tammy Schroeder
859-335-9041 ext. 237, 513-257-9011 cell

Agreement and Release Form

Agreement: I do hereby warrant the completeness and accuracy of the information contained in this credentialing package, and that I have not intentionally withheld any information.

Release: I understand that in order to continue the credentialing process, Marshall Emergency Services Associates (MESA) must have reasonable access to all pertinent and relevant information concerning my professional history and conduct. I hereby authorize and direct any medical professional, hospital, educational institution, post-graduate training program, medical society, and insurance company to furnish any information that MESA may request.

Signature

Printed Name

Date