

HOSPITAL ADDENDUM J
to the Texas Dept of Insurance Texas Standard Credentialing Application (TSCA)
for **Initial and Reappointment Application**

II. Additional Disclosure Questions:

If you answer 'yes' to any questions in the section below, please submit a detailed explanation as an attachment.

1. Have any investigations, disciplinary actions or challenges ever been initiated, or are any currently pending against you, by any state licensure or registration board? Yes No
2. Has your license or registration in any state ever been limited or have you voluntarily or involuntarily relinquished such? Yes No
3. Have you ever been the subject of disciplinary proceedings or placed under monitoring or supervision at any hospital or health care facility? Yes No
5. Has your application for, or membership in, any medical/professional society/association been voluntarily or involuntarily withdrawn, denied, suspended, revoked or not renewed or are there any actions currently pending that would affect your membership in such. Yes No
6. Has your employment, clinical privileges or Medical Staff membership at any hospital or other healthcare institution ever been refused, voluntarily or involuntarily terminated, surrendered, or subject to voluntary or involuntary limitation, reduction or loss of clinical privileges? (for reasons other than non-completion of medical records when quality of care was not adversely affected) Yes No
7. Have you voluntarily or involuntarily withdrawn your application for appointment or reappointment, clinical privileges or employment, or resigned from the staff or place of employment before a decision was made by the hospital's or health care entity's governing board? Yes No
8. Have you been the subject of any investigation, proceeding or litigation challenging or sanctioning your patient admission, treatment, discharge, charging, correction or utilization practices? Yes No
9. Has your specialty board certification or eligibility been voluntarily or involuntarily relinquished, denied, not renewed, suspended, reduced or have proceedings toward these ends been instituted? Yes No
10. Has your Federal DEA and/or DPS Controlled Substances Authorizations been limited, voluntarily or involuntarily relinquished, or is it currently being challenged? Yes No
11. Have you ever been charged with or convicted of any crime related to your clinical practice including Medicare or Medicaid related crimes or have you ever been subject to civil money penalties under the Medicare or Medicaid program? Yes No

12. Since October 6, 2003, have you had or currently have, a financial equity interest, direct or indirect, in a hospital within a twenty-five (25) mile radius of Covenant Health System facilities? Yes No
- if Yes please provide the name of hospital _____ date acquired _____
- if No _____ I acknowledge that it will be my responsibility to notify Covenant Health System immediately of subsequent acquisition of any hospital equity interests.
13. Has your professional liability insurance coverage ever been denied, terminated or rated in a higher than average risk class for your specialty? Yes No
14. Have any procedures been excluded from your professional liability coverage? Yes No
15. Has a judgment or settlement been made against you or are any pending? Yes No
16. Is there any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against you? Yes No
17. Have you ever been arrested for or convicted of any offense, placed on probation, or granted deferred adjudication or any other type of pre-trial diversion? (You may exclude minor traffic violations but must report any offense involving alcohol or drugs.) Yes No
18. To you knowledge, are you currently the subject of a grand jury or criminal investigation? Yes No

III. Physicians Only:

List all non-physician providers who will assist you at any Covenant Health System entity. This includes but is not limited to RN's, LVN's, Surgical Tech's, PA's, NP's, CFA's
Please note: *All Affiliate & Allied Health Professionals must be approved through a separate credentialing process prior to providing patient care & service at Covenant Health System..*
 Name Professional Designation

_____	_____
_____	_____
_____	_____
_____	_____

(attach additional documentation if necessary)

IV. HEALTH STATUS

Please describe your current health status: Good _____ Fair _____ Poor _____

V. PERSONAL (optional)

Spouse's name: _____

VI. Continuing Medical Education

Have you met the minimum continuing medical education requirements for renewal of your license in the past two years? Yes No