ELIGIBILITY FOR PARTICIPATION FORM

Northeast Louisiana Physician Hospital Organization
Community Health Integrated Network of Northeast Louisiana

Applications for participation shall only be provided to practitioners who meet the following criteria for eligibility. If, during processing, an applicant does not meet all of the minimum qualifications, no further processing of the request shall occur.

1. I have a current, unrestricted license to practice in Louisiana and have never had a license to practice revoked or suspended by any state licensing agency ☐ *true* ☐ *false*

2. I have a current, unrestricted DEA registration (*with a Louisiana address*) and state controlled substance license, where applicable to their practice ☐ *true* ☐ *false*

3. I have no gap in work history exceeding six (6) months ☐ *true* ☐ *false*

4. I have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same ☐ *true* ☐ *false*

5. I have never been, and not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program ☐ *true* ☐ *false*

6. I have never had Medical Staff appointment or clinical privileges denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, and have never resigned appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation ☐ *true* ☐ *false*

7. I have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence ☐ *true* ☐ *false*

8. I have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) or the counsel on Podiatric Medical Education of the American Podiatric Medical Association, in a specialty appropriate to the clinical privileges specifically requested or be Board Certified by a board recognized by the American Board of Medical Specialties for a specialty appropriate to the specific clinical privileges requested. Appropriateness of the residency program or board certification shall be determined by the Credentials Committee in its sole and absolute discretion ☐ *true* ☐ *false* ☐ *N/A*

I attest that the answers to the above questions are correct to the best of my knowledge & belief.

_____	_____
SIGNATURE	PRACTICE NAME
_____	_____
PRINT NAME	SPECIALTY
_____	_____
DATE	PHONE NUMBER OR EMAIL ADDRESS