EMORY
JOHNS CREEK
HOSPITAL

6325 Hospital Parkway
Johns Creek, Georgia 30097
Phone 678-474-7000
emoryjohnscreek.com

Dear Provider,

Thank you for your recent inquiry in credentialing at Emory Johns Creek Hospital (EJCH). Through our affiliation with Emory Healthcare, we are pleased to announce that our application process is now conducted on-line. To begin this process, please complete the attached Request for Application and return it to us, along with all requested attachments. Upon receipt of your request form, we will email you a link to complete the on-line application.

Under most circumstances, the credentialing process requires 60-90 days for completion so please plan accordingly.

If you have any questions, please do not hesitate to contact us. Please submit the attached application request with required copies. We look forward to working with you soon!

Sincerely,

Mary Showalter, MBA, CPMSM, CPCS
Manager, Medical Staff Office – EJCH
Hospital Office: 678-474-7024; Fax: 678-474-7034
Mary.Showalter@emoryhealthcare.org

Serge Rolin
Credentialing Specialist – EJCH
Hospital Office: 678-474-7194; Fax: 678-474-7196
Serge.rolin@emoryhealthcare.org

Liz Mitchell
Medical Staff Liaison – EJCH
Hospital Office: 678-474-7036; Fax: 678-474-7039
Lizabeth.mitchell@emoryhealthcare.org

REQUEST FOR APPLICATION

ALL INFORMATION IS REQUIRED IF APPLICABLE TO APPLICANT

DATE OF REQUEST________\ ____ **ESTIMATED EJC START DATE____________**

ESTIMATED Group START DATE________\ ____

CREDENTIALING REQUEST (SELECT ONE):
☐ New Hire/Initial Request ☐ Adding a Facility

ENTITY REQUESTING (*Please indicate all entities for which you are requesting privileges)
☐ Emory Saint Joseph's Hospital
☐ Emory University Hospital Midtown
☐ Emory Johns Creek Hospital

PROVIDER FULL NAME: ____

PROVIDER TYPE/TITLE (MD, DO, PA, etc.):_______________ **DATE OF BIRTH:** ________________

SSN# (required):_________-__________- _________ **NPI #:** ______________________________

GA LICENSE #: __________________________ **DEA #:** ______________________________

EMAIL ADDRESS: ____
***Invitation will be sent to this email address to complete the application**

PRACTICING SPECIALTY: ____

NAME OF YOUR BOARD CERTIFICATION/ QUALIFICATIONS:

____

RESIDENCE ADDRESS: ____

RESIDENCE PHONE #: ______________________________

DO YOU MAINTAIN A RESIDENCE AND OFFICE PRACTICE WITHIN 45 MINUTES OF EMORY JOHNS CREEK? ______YES ______NO

PRIMARY PRACTICE NAME: ____

ADDRESS: ____

PHONE #: ______________________________ **FAX #:** ______________________________

CELL #: ______________________________ **TIN#:** ______________________________

CREDENTIALING CONTACT NAME/TITLE: ______________________________

PHONE #: ______________________________ **EMAIL:** ______________________________

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1. **Have you ever previously been, or applied to be, credentialed at Emory Johns Creek Hospital?**

   Yes_______ No _______

   If yes, indicate dates of previous affiliation:______________to ______________

2. Reason for your interest in joining Emory Johns Creek Medical Staff:

   ____
   ____
   ____

3. **Are you joining a group____or sharing call_____with physicians currently on staff at Emory Johns Creek?** If so list members sharing call or members of the group:

   ____
   ____

4. **Where, in addition to Emory Johns Creek, are you planning to apply for medical staff membership and clinical privileges?**

   ____
   ____

5. **To what extent do you anticipate using the facilities at Emory Johns Creek Hospital?**

	Approximate Annual Number	Percentage of Your Annual Practice
Admissions		
Outpatient Procedures		
Inpatient Procedures		
Consultations		
Use of Hospitalist Service		
Referring Patients to the EUHM Outpatient Infusion Center located on EJC Campus *(Requires application to Emory University Midtown Medical Staff). That application can be processed with your application to Emory Johns Creek.*		

6. **Malpractice:** Have you ever been involved in any professional liability actions (i.e. malpractice) claims, suits, judgments, settlements, mediations, or arbitration proceedings, or are any such proceedings currently pending?

   ( ) Yes ( ) No If yes, give full details on separate sheet.

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7. Licensure

- Has your license to practice in any jurisdiction ever been voluntarily or involuntarily revoked, suspended, challenged, investigated, placed on probation, reduced, relinquished denied or not renewed or is such action currently pending?
  ( ) Yes ( ) No If yes, give full details on separate sheet.

- Have you ever been asked to surrender your license or have you ever been reprimanded or otherwise sanctioned by, or had conditions placed on your license in any jurisdiction?
  ( ) Yes ( ) No If yes, give full details on separate sheet.

8. Sanctions

- Have you ever been subject to voluntary or involuntary suspension, sanction or otherwise restricted from participating in the Medicare, Medicaid or any other federal, state or private insurance programs or are you currently being investigated in a matter that could lead to exclusion from such program participation?
  ( ) Yes ( ) No If yes, give full details on separate sheet.

- Have you ever been arrested for or charged with any crime?
  ( ) Yes ( ) No If yes, give full details on separate sheet.

- Have you ever been convicted of any felony, or of any misdemeanor relating to controlled substances, illegal drugs, Medicare, Medicaid, or other insurance fraud or abuse, or violence?
  ( ) Yes ( ) No If yes, give full details on separate sheet.

9. DEA

- Has your narcotic license ever been voluntarily or involuntarily revoked, suspended, challenged, investigated, placed on probation, reduced, relinquished or not renewed in the past five years?
  ( ) Yes ( ) No If yes, give full details on separate sheet.

10. Hospital affiliations

- Have you ever been subject to voluntary or involuntary termination of medical staff membership or voluntary or involuntary denial, limitation, reduction, restriction, loss, or change of clinical privileges at another hospital or other health care institution in the past five years?
  ( ) Yes ( ) No If yes, give full details on separate sheet.

- Have you ever received any type of sanction, been the subject of an investigation or are you currently under investigation by a hospital, state licensing agency or any other professional healthcare organization?
  ( ) Yes ( ) No If yes, give full details on separate sheet.

11. Are you employed by any other hospital or its affiliate?
( ) Yes ( ) No If yes, give full details on separate sheet.

12. Do you have any business interests (including, but not limited to, ownership or investment interests) in any freestanding health care provider?
( ) Yes ( ) No If yes, give full details on separate sheet.

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13. Does your professional liability insurance carrier have a minimum AM Best rating of A+ and financial size category of V?

( ) Yes ( ) No

14. Has a patient, practice employee, hospital employee or other physician ever lodged a complaint against you involving any of the following types of behavior: sexual harassment, using threatening, profane or abusive language, inappropriate physical contact with another individual, or any other type of disruptive behavior?

( ) Yes ( ) No If yes, give full details on separate sheet.

In making your request for an application to Emory Johns Creek Hospital Medical Staff, please be aware of several obligations of staff membership, which are requirements:

1. Certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties (“ABMS”), the AOA, the American Board of Oral and Maxillofacial Surgery, the ADA, or the American Board of Podiatric Surgery, as applicable. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training
2. Professional Malpractice Insurance Coverage of 1M/3M.
3. Compliance with meeting requirements.
4. Compliance with Emergency Department call requirements of your Department and/or Section.
5. Care for unassigned patients and charity care obligations.

Return with copies of the following with this application. *(Please explain pending documents.)*

1. Current, unrestricted license to practice medicine in the State of Georgia.
2. Current Government Issued ID
3. Evidence of accepted board certification status.
4. Evidence of successful completion of an ACGME accredited postgraduate residency program or podiatric residency training at a program approved by the Council on Podiatric Medical Education.
5. Proof of current DEA registration.
6. Copy of professional liability insurance face sheet indicating effective date, amounts of coverage and classification of coverage. (hospital requirements $1M/3M)
7. Current curriculum vitae.

I request an application for appointment to the Medical Staff of Emory Johns Creek Hospital.

Applicant’s Signature:____Date __________

Please submit your completed application request form to: Serge Rolin or Liz Mitchell