ELDERWOOD ADMINISTRATIVE SERVICES
500 Seneca St., Suite 100 / Buffalo, New York 14204 / (716) 633-3900

HEALTH PROFESSIONAL APPLICATION AND AGREEMENT

PLEASE COMPLETE ALL SECTIONS AND RELEVANT CHECK BOXES

DEMOGRAPHIC INFORMATION		
Profession		
First Name	M.I.	Last Name
Home Address		
City	State	Zip Code
Phone No.	Cell No.	
Email		
Date of Birth	State License No.	
NPI No.	Tax ID No.	

Group Name		
Practice Address		
City	State	Zip Code
Office Phone Number	Fax Number	

Alternate/Covering Practitioner		
Practice Address		
City	State	Zip Code
Office Number	Fax Number	

Name of Supervisor		
Practice Address		
City	State	Zip Code
Office Phone Number	Fax Number	

COMPLETE ALL THAT APPLIES

EDUCATION		
School		
Address		
City	State	Zip Code
Phone Number	Year Graduated	

POST GRADUATE EDUCATION/TRAINING		
School	Education/ Training	
Address		
City	State	Zip Code
Phone Number	Year Graduated	

INTERNSHIP		
Place of Internship	Internship type	Year Completed
Address		
City	State	Zip Code

FELLOWSHIP TRAINING	
Place of Fellowship	Year Completed
Address	
City	State	Zip Code

CERTIFICATION		
Board Certification		Year
Board Certification		Year
Recertification ☐ Yes ☐ No	Board Eligibility ☐ Yes ☐ No	Date of Application: ____/____/_____
Specialty		
Membership in Professional Societies/Organizations		

HOSPITAL or FACILITIES- List all hospitals or facilities (in all states) you have been associated with over the past ten years. Provide dates of association.	
Hospital/Facility	Years of Association
Hospital/Facility	Years of Association
Hospital/Facility	Years of Association
Hospital/Facility	Years of Association
Have your privileges to practice ever been restricted, suspended, curtailed or discontinued at any of the above facilities? ☐ Yes ☐ No If answer is yes, please provide details of situation(s).	
Are you involved in any pending professional malpractice actions or professional misconduct proceedings for your professional practice? ☐ Yes ☐ No If answer is yes, please provide details of situation(s).	

Signature Log is required to verify signature(s) of all Healthcare Professionals as identified on all documentation in the medical record. Please print and sign your name, professional designation and initials:

Name as it appears on Your professional license (please print)	**Signature**	**Professional Designation**	**Initials**

MEDICAL RECORDS SYSTEM – POINT CLICK CARE

Tiger Text User Name

Tiger Text is required for Secure Conversations if you service more than one organization with PointClick Care or if you prefer to receive all messages on your preexisting account. An information packet regarding setting up a Tiger Text account will be provided during training. A business email address is required for setup.

Do you currently have a Tiger Text Account? ☐ Yes ☐ No	**If Yes please provide the email address associated with this account.**

Point Click Care EMR Training Needs

Elderwood offers providers basic Navigation Training.

Please select what type of training you require and what method of training you prefer. If you do prefer training, our Instructional Support Specialist will be contacting you once the credentialing process and security setup is complete.

☐ I do not require any training	☐ I prefer self-learning materials
☐ I require basic navigation training	☐ I prefer live training by Elderwood
☐ I require ePrescribing training	

CODE OF CONDUCT — REQUIRED FOR ALL

- o I have received and reviewed a copy of the Companies Code of Conduct Principles, False Claims and Deficit Reduction Act information, and compliance program overview. I have read, understand and acknowledge their contents and accept all the responsibilities they impose on my association with the company. I understand that I have the opportunity to ask questions and discuss any aspects of the Code of Conduct with the Compliance Officer or any member of the Companies management team if I am unsure of how the code applies in any situation
- o I specifically acknowledge my affirmative obligation to adhere to the principles and standards of the Code of Conduct, and to report in good faith and in accordance with the Codes provisions, any violations or suspected violations of which I become aware.

HEALTH STATUS/MEDICAL SERVICES AGREEMENT — REQUIRED FOR ALL

TB Screening Per facility policy, initial and annual TB screening is required for all medical professionals. (Select one below)

- o I have attached the negative results of a completed TST test with in the last 12 months.
- o I have a history of a positive TST test and I have attached a negative Chest x-ray completed within the last 5 years.

Influenza Vaccination Per facility policy, if the annual influenza vaccination is not received, all medical professionals are required to wear a surgical mask during flu season.

- o I have attached proof of my vaccination
- o It is not flu season, and vaccination documentation is not required
- o I am unvaccinated and agree to wear a surgical mask during flu season.

Attestation

- o I attest that I am free of Illegal drug use, free of communicable disease and am capable of carrying out my duties with or without reasonable accommodation.

- o I understand I am required to provide a current copy of the following:
  - State professional registration certificate
  - Certificate of Professional Liability Insurance
  - Government issued Photo ID (Drivers license, passport, etc.)

I verify that the above information is true and accurate. I will comply with all applicable federal, state, and local laws or regulations, and facility policies that apply to providing medical services for a resident of Elderwood.

_____ ____ /_____/_____

Signature of Professional/Consultant **Date**

Residents are admitted and treated at this facility without regard to race, color, national origin, creed, religion, age, sex, sexual preference, sponsor, blindness or other disability