

Please mail the completed application to:

**Dentserv**  
**15 Canal Road**  
**Pelham Manor, New York 10803**

Applications can also be faxed to **914.738.0331**.

All applications should be completed in their entirety and include:

- *Application for Clinical Privileges (enclosed)*
- *Two reference request forms (enclosed)*
- *Consent and release authorization form (enclosed)*
- *A photocopy of your New York State triennial registration*
- *A photocopy of your malpractice policy indicating name of carrier, type and extent of coverage and expiration date.*
- *A copy of your resume or curriculum vitae*

APPLICATION FOR CLINICAL PRIVILEGES

I. Identification

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Office Phone#: \_\_\_\_\_

Home Phone# \_\_\_\_\_

Social Security #: \_\_\_\_\_

II. Professional Education

Name of Professional School	Location	Dates Attended		Degree
		From	To	

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

III. Post Graduate Training (Internship, Residency, Fellowships)

Name of Hospital/ Institution	Location	Program (residency etc)	Dates	
			From	To

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

IV. Licensure / Certification

LICENSURE

Answer the following question(s). If the answer is yes, you must provide a full explanation\* below or attach a separate sheet.

Have any disciplinary actions been initiated, or are any pending against you by a licensing board in this State or any other State?

YES [ ] NO [ ]

Has your license to practice in this state or any other state ever been denied, limited, or been voluntarily or involuntarily suspended or revoked?

YES [ ] NO [ ]

List all states by which you are, or have ever been licensed to practice dentistry. Include license numbers and dates issued. All licenses must be listed even if no longer in effect.

OTHER LICENSES:

STATE	LICENSE#	DATE ISSUED	DATE OF EXPIRATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(If additional space is required please attach a separate sheet)

\*EXPLANATION:

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V. INSTITUTIONAL AFFILIATIONS

Answer the following question(s). If the answer is yes, you must provide a full explanation on a separate sheet and attach.

Has your employment, Medical staff appointment, or privileges ever been suspended, diminished, revoked, or refused at any hospital or other health care facility?

Yes [ ] No [ ]

Have you ever voluntarily or involuntarily resigned from Medical Staff appointment, clinical privileges, or employment at any hospital, other health care facility or organization?

Yes [ ] No [ ]

List in chronological order ALL health care affiliations within the last ten (10) years. Complete addresses must be included. If more space is needed attach additional sheets.

Institution

Name: \_\_\_\_\_

from: \_\_\_\_\_ To: \_\_\_\_\_

Category of Appointment: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Department: \_\_\_\_\_

Chairman: \_\_\_\_\_  
\_\_\_\_\_

Institution

Name: \_\_\_\_\_

from: \_\_\_\_\_ To: \_\_\_\_\_

Category of Appointment: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Department: \_\_\_\_\_

Chairman: \_\_\_\_\_

Institution

Name: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

Category of Appointment: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Department: \_\_\_\_\_

Chairman: \_\_\_\_\_

VI. BOARD CERTIFICATIONS

Answer the following question(s). If the answer is yes, you must provide a full explanation below.

Have you ever been examined by any specialty board, but failed to pass?  
YES [ ] NO [ ] If yes, how many times? \_\_\_\_\_

List names of specialty boards by which you are certified. (Evidence of Board Certification must be attached)

American Board of \_\_\_\_\_

Status: \_\_\_\_\_

Date Issued: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Explanation:

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VII. DISCIPLINARY ACTIONS

In accordance with the current State and Federal regulations we are required to ask and you are required to respond to the following questions. If the answer to any of the questions is yes, a full explanation must be provided.

Have any of the following ever been, or currently in the process of being denied, revoked, suspended, reduced, limited, terminated, placed on probation, not renewed, voluntary or involuntary relinquished, or have you ever withdrawn or failed to proceed with an application for the following:

- a. Dental License in any state Yes[] No[]
- b. Other professional registration/license Yes[] No[]
- c. DEA/Controlled substance registration Yes[] No[]
- e. Membership on any health care facility staff Yes[] No[]
- f. Clinical privileges, training, employment, association Yes[] No[]
- g. Other institutional affiliation or status there at Yes[] No[]
- h. Professional society membership or fellowship/board certification Yes[] No[]
- i. Any other type of professional sanction Yes[] No[]
- j. Professional liability insurance Yes[] No[]

Has your association, employment, practice and/or privileges at any hospital or health care facility ever been limited or discontinued for any reason?

YES [ ] NO [ ]

Have you ever been involved in any medical, dental, or other misconduct proceedings in this State or any other State?

YES [ ] NO [ ]

Have you ever been involved in any medical, dental, or other malpractice actions in this State or any other State?

YES [ ] NO [ ] \* If YES, was the matter:

- a. settled prior to final court action? [] yes [] no
- b. judgement rendered by court? [] yes [] no
- c. defendant found liable? [] yes [] no
- d. matter still pending [] yes [] no

Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program?

YES [ ] NO [ ]

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?

YES [ ] NO [ ]

Have you ever been named as a defendant in any criminal proceeding?

YES [ ] NO [ ]

Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings in any professional organization?

YES [ ] NO [ ]

Has your narcotics registration ever been suspended or revoked?

YES [ ] NO [ ]

Have you ever been investigated or censured for violation/s of patients rights?

YES [ ] NO [ ]

VIII. PROFESSIONAL LIABILITY INSURANCE

List all professional liability insurance carriers for the previous ten (10) years. If additional space is needed, please attach sheet.

Carrier Name: \_\_\_\_\_ Address \_\_\_\_\_  
 Policy#: \_\_\_\_\_  
 Coverage Limits: \_\_\_\_\_  
 Expiration Date: \_\_\_\_\_

Carrier Name: \_\_\_\_\_ Address \_\_\_\_\_  
 Policy#: \_\_\_\_\_  
 Coverage Limits: \_\_\_\_\_  
 Expiration Date: \_\_\_\_\_

Carrier Name: \_\_\_\_\_ Address \_\_\_\_\_  
 Policy#: \_\_\_\_\_  
 Coverage Limits: \_\_\_\_\_  
 Expiration Date: \_\_\_\_\_

Have any professional liability suits ever been filed against you in this State or any other state? Yes [ ] No [ ]

\*If yes, review the attached history currently on file and report any additional actions or changes in status below:

Pending Action(s)

Name of Claimant	Date of Occurrence/Action	Nature of Claim	Status
_____	_____	_____	_____
_____	_____	_____	_____

Judgements/Settlements

Name of Claimant	Date of Occurrence/Action	Nature of Claim	Status
_____	_____	_____	_____
_____	_____	_____	_____

IX.

MEDICAL HISTORY

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Please answer whether you have (or had) any of the following and give date of onset:

- Typhoid Fever  Yes  No date of onset \_\_\_\_\_
- tuberculosis  Yes  No date of onset \_\_\_\_\_
- Diabetes  Yes  No date of onset \_\_\_\_\_
- Mental or Emotional illness  Yes  No date of onset \_\_\_\_\_
- Epilepsy  Yes  No date of onset \_\_\_\_\_
- Back Problems  Yes  No date of onset \_\_\_\_\_
- Cardiac Problems  Yes  No date of onset \_\_\_\_\_
- Hypertension  Yes  No date of onset \_\_\_\_\_
- Chicken Pox  Yes  No date of onset \_\_\_\_\_
- Infectious Mononucleosis  Yes  No date of onset \_\_\_\_\_
- Hepatitis A or B  Yes  No date of onset \_\_\_\_\_
- Blood/lymph disease
  - Leukemia or Hodgkins  Yes  No date of onset \_\_\_\_\_
  - Other \_\_\_\_\_  Yes  No date of onset \_\_\_\_\_

If you have answered yes to any of the above, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you take corticosteroids (prednisone, cortisone)?  Yes  No If yes please explain: \_\_\_\_\_

Are you taking any immunosuppressive drugs (azathioprine, cycloserine, murcomonab)?  Yes  No If yes, please explain: \_\_\_\_\_

List all currently prescribed medications:  
\_\_\_\_\_  
\_\_\_\_\_

Are you habituated or addicted to depressants, stimulants, narcotics, alcohol or other substances?  Yes  No If yes, please explain: \_\_\_\_\_

Please list all allergies, if any: \_\_\_\_\_

If you have been hospitalized in the past 5 years, please explain and give details (include year, diagnosis, surgery and treatment): \_\_\_\_\_

If you have had a major illness in the past, please explain and give details:  
\_\_\_\_\_  
\_\_\_\_\_

IX. Medical History continued

Tuberculosis Screening

1. Do you have any of the following symptoms:  
If Yes Please Explain

- Fever  Yes  No \_\_\_\_\_
- Tiredness  Yes  No \_\_\_\_\_
- Weakness  Yes  No \_\_\_\_\_
- Night Sweats  Yes  No \_\_\_\_\_
- Loss of Appetite  Yes  No \_\_\_\_\_
- Unexplained Weight Loss  Yes  No \_\_\_\_\_
- Swelling in Neck, Armpits Groin  Yes  No \_\_\_\_\_
- Cough with Sputum  Yes  No \_\_\_\_\_
- Blood Tinged Sputum  Yes  No \_\_\_\_\_

2. Do you have a history of induration, sensitivity, and/or allergy to PPD testing?  
 Yes  No Date of Last PPD \_\_\_\_\_ Results: Negative \_\_\_\_\_ Positive \_\_\_\_\_

3. Have you ever received a course of prophylactic treatment for TB?  
 Yes  No If yes, complete the following:  
Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
Medications: \_\_\_\_\_

4. Have you received a BCG vaccine within the past 10 years?  
 Yes  No If yes, date of BCG Vaccine: \_\_\_\_\_

Do you have any physical or medical conditions which may limit your ability to perform your particular duties?  Yes  No If yes, please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

X.

The information given in or attached to this application is accurate and fairly represents the current level of my training, experience, capability, and competence to practice dentistry. As a condition to making this application, any misrepresentation or misstatement in, or omission from this application, whether intentional or not, shall constitute cause for immediate rejection of this application resulting in denial of appointment. In the event that appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of such appointment.

I understand and agree that I, as an applicant for clinical privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

I further acknowledge that I am familiar with the principles and standards of the Joint Commission on Accreditation (JCAHO), and will cooperate with Dentserv in maintaining such standards.

In making this application for clinical privileges at Dentserv, I acknowledge my obligation to provide continuous care and supervision of my patients, to accept committee assignments, to accept consultation assignments and to participate in staffing the emergency area and other specialty care units. I also agree to conduct any practice according to high ethical traditions, I particularly agree to subject my clinical performance to and faithfully participate in, Dentserv's quality assurance programs as the same from time to time be in effect.

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Signature

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Date

Consent and Release

I fully understand that any significant misstatement in or omissions from this application for appointment/reappointment constitute cause for denial of appointment or cause for summary dismissal from the Dentserv Dental Services, P.C. staff. All information submitted by me in this application (including attachments) is true to my best knowledge and belief. I agree to update this application should there be any change in the information provided.

In making this application for appointment/reappointment of Dentserv, I acknowledge that I have received and read the service agreement and rules and regulations. I agree to be bound by the terms thereof if I am granted membership or clinical privileges, and I further agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment to Dentserv.

By applying for appointment/reappointment to the Dentserv staff, I hereby signify my willingness to appear for interviews in regard to my appointment/reappointment, authorize Dentserv, its staff and their representatives to consult with administrators and members of medical staff of other hospital or institutions with which I have been associated and with others, including but not limited to past and present malpractice carriers, professional societies, specialty boards and professional schools and training programs who may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release from liability Dentserv, all representatives of Dentserv, and its staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to Dentserv, or its staff, in good faith and without malice concerning my professional competence, ethics character and other qualifications for staff appointment/reappointment and clinical privileges, and I hereby consent to release of such information.

I hereby further authorize and consent to the release of information by representatives of Dentserv, or its staff, to other hospital and healthcare facilities, or their medical staffs, licensing boards and medical associations on request regarding any information Dentserv and the staff may have concerning me as long as such release of information is done in good faith, without malice, and in accordance with Federal and State laws, and I hereby release from liability Dentserv, its staff and their authorized representatives to the full extent permitted by law for so doing. Nothing in this document shall be construed as limited or superseding any immunities otherwise provided by law.

I understand and agree that I, as an applicant for staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. I agree that further verification of my identity may be obtained if deemed necessary by Dentserv, (by use of my photograph). I will not participate in any form of illegal fee-splitting.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name Typed/Printed: \_\_\_\_\_

REFERENCE REQUEST

PLEASE PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE INDIVIDUAL TO WHOM WE MAY SEND YOUR REFERENCE REQUEST TO:

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

TELEPHONE#: \_\_\_\_\_

I hereby authorize the above captioned to release confidential information about me to Dentserv Dental Services, PC.. I release from liability any and all individuals, organizations who provide such information concerning my professional competence, ethics, character and other qualifications for clinical privileges.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

DO NOT WRITE BELOW THIS LINE

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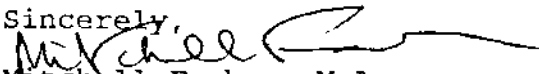
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Subject: Professional Reference for:  
\_\_\_\_\_

Dear Doctor:

The above captioned practitioner has applied for appointment to the Dental Staff of Dentserv Dental Services PC, and has given your name as a professional reference. Based on your personal knowledge, we would appreciate your candid, written appraisal. The attached professional reference questionnaire includes information relevant to our consideration of the practitioner's qualifications for appointment and privileges.

In your reply, please provide any knowledge you have of these matters with respect to this individual. Enclosed is copy of their consent for the release of this information. I have also enclosed a prepaid return envelope for your convenience. Your prompt response to our request is greatly appreciated.

Sincerely,  
  
Mitchell Farber, M.A.  
Director of Operations