Anderson Hospital

6800 State Route 162
Maryville, Illinois 62062
618-391-6140 ◆ 618-391-6141
618-288-2164 FAX
MSO@AndersonHospital.org

Re: Application Documentation

Dear Applicant:

Enclosed please find the State of Illinois Health Care Professional Credentialing and Business Data Gathering Form. This is a State Mandated form and must be received in order to apply for membership and/or privileges at Anderson Hospital. Your application will be processed in accordance with the Medical Staff By-Laws, Rules and Regulations. This form may also be obtained from the website, downloaded as a Word document, completed and saved on your computer.

The website address is www.idph.state.il.us. Once on the website, click on "Topics & Services". Click on "Health Care Regulation". Click on "Health Care Facilities". Click on "Hospitals". Scroll down and on the right hand side you will find the forms under "Forms".

PLEASE MAKE SURE TO COMPLETE THE CORRECT FORM ☐CREDENTIALING VS. RECREDENTIALING. If a section or question does not apply to you such as additional names known by you ☐ then mark N/A. PLEASE make sure every line and or box is completed. This includes the additional Form A ☐F that must be completed if any questions are answered yes on pages 19-21. If there are any blanks the application will be considered incomplete and the form will be returned to you for completion.

In addition to the State of Illinois Mandated form, we are also requesting completion of facility specific documents. These are:

- ✓ Anderson Hospital Supplemental Information Form (3 pages) ***NOTE: the last page of this form requests the staff category you are applying for ☐please read the attached category sheet and determine which category best suits your needs. All Active members will be placed on a committee meeting assignment. If you wish to request Membership only ☐please indicate.***
- ✓ Anderson Hospital ☐Applicant☒Attestation (1 page)(**original signature required)**
- ✓ Anderson Hospital ☐Medical Staff member Consent and Release (1 page)**(original signature required)**
- ✓ Anderson Hospital ☐Health Statement (1 page) ***NOTE: Please sign the form at the top and forward to your private physician or schedule your physical with your private physician and have them complete the form and return to our office via mail or fax. (618)288-2164***
- ✓ MHA Management Services Corporation ☐Background Check Request Form ☐this form MUST be completed in order for the Medical Staff Office to run a State of Illinois **required** Health Care background check. We cannot run a check without **ALL** of the information requested in the top section (complete ***every box*** from ☐ame☐ through ☐ate☐). The bottom is for our use only. Any forms returned with required information missing will be returned. **(completed original copy with original signature must be returned)**
- ✓ Anderson Hospital Conflict of Interest Agreement ☐This form must be completed ☐if you have no conflicts then please indicate this in the area provided. **(original signature required)**
- ✓ Auto Fax Enrollment Form ☐if you wish to receive faxed reports
- ✓ Notice to Physicians regarding CHAMPUS, Medicare, Medicaid ☐**REQUIRED and must be Original**
- ✓ Malpractice Insurance ☐read page 1 and complete and sign pages 2 and 3
- ✓ Delineation of Privilege Forms ☐Please check the privileges requested and provide proof of competency by submitting your case logs for the past 12 months. If the form is not checked and the logs are not received with the application ☐it will be deemed incomplete.
- ✓ Signature Card
- ✓ Provider Contact Information (in order by preference)
- ✓ Peer Reference forms (Please send to at least three references)

It is the obligation of the applicant to provide information on the matters listed in the application to the satisfaction of the hospital. **An application must be completed within one hundred and eighty (180) days. Time begins upon our receipt of the *completed* application. This time frame also includes the hospital verification process required for our application procedure □this process will go faster if full address, fax numbers and/or emails are supplied. An application will not be presented to the Credentials Committee until it is Complete**.

Failure to provide all information listed above within the above stated time frame shall be construed as withdrawal of the application.

A checklist is enclosed to assist you in completing your application packet. This checklist includes instructions for completing the state mandated form, and also lists additional forms that must accompany your application to deem your application complete.

We look forward to receiving your completed application. If you have any questions, please feel free to contact the Medical Staff Office at the contact information above.

Sincerely,

Brett Grebing, MD

Brett Grebing, MD □President of the Medical Staff