AESTHETX

Thank you for your interest in obtaining privileges at Aesthetx Surgery Center.

Enclosed please find an application for Medical Staff appointment and the Delineation of Privileges in your specialty.

Please return the following items along with your original completed application and DOP so that we may process your application promptly.

- Color Copy of Government Issued Photo ID (CDL acceptable)
- Current California Medical License
- DEA Certificate
- Malpractice Insurance Certificate
- Copy of approved privileges from most active facility/hospital
- Fluoroscopy Certificate (if applicable)
- Curriculum Vitae
- Board Certificate (if applicable)
- CME
- Provide Two Peer Review Names And Email Addresses
- Current TB Test
- Current Flu Vaccination Documentation
- Hep B Vaccination/Declination
- Covid-19 Vaccination Card/Declination
- Covid-19 Omicron Vaccination/Declination

An application will not be started until all items are submitted. Please note all documents need a wet signature. Thank you.

Sincerely,

Aesthetx Surgery Center

7500 Grand Ave, Suite 200
Gurnee, Illinois 60031

Toll Free: 1-888-545-5222
Phone: 847-775-1970
Fax: 847-775-1985
reception@aaaasf.org
www.aaaasf.org

REQUEST TO ADD PHYSICIAN

Each physician, podiatrist, or oral and maxillofacial surgeon using the facility must be credentialed and qualified for the procedures they perform.

In order to add a doctor to staff the facility director and the new physician must sign this request as well as include the following credentials:

- Copy of current State Medical License
- Copy of Board Certification or eligibility
- Hospital Appointment (or reappointment) Letter
- Delineation of Hospital Privileges (list of procedures)

I authorize and request that the physician listed below be added to facility ID # 6742

New Physician Name: _____

Facility Director Signature: _____

Printed Name: _____

AUTHORIZATION TO RELEASE INFORMATION

In furtherance of my facility's application for accreditation and continued accreditation by the American Association for Accreditation of Ambulatory Surgery Facilities, Inc., I hereby request and authorize any hospital, any medical staff or any other medical organization with which I am now or have been affiliated to provide information concerning my current or former status with such organization(s). I hereby release from liability any hospital, medical staff or other medical organization for acts performed in connection with the collection of evaluation and submission of such information concerning my status to the American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

_____

Name of New Physician

X _____

Signature of New Physician

AESTHETX

HEALTH PROFESSIONAL APPLICATION

Name: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Home Address: _____

Home Phone _____ Social Security No: _____

Date of Birth: _____ Place of Birth: _____

Supervising Physician: _____

Office Address: _____

List institutions where you currently have privileges and your status:

_____

_____

Have you practiced in any other community? ___Yes___ ___No___

If yes, where? _____

_____

Have you ever been under investigation by any health care facility review committee and/or had privileges in any health care facility denied, rescinded, limited, suspended, and/or not renewed? Yes _____ No _____

If yes, identify institution(s) and explain circumstances: _____

_____

Have you ever been convicted of a felony? Yes _____ No _____
Are there any charges pending? Yes _____ No _____
If yes, please explain: _____

_____

Have you ever been charged with any form of substance abuse or ever received treatment of such in any healthcare facility or treatment program? Yes _____ No _____
If yes, please explain: _____

INSURANCE INFORMATION
*If sponsored by a physician and included within the coverage provided by his/her professional liability insurance list his/her information here, otherwise list applicant information.

Insurance Carrier: _____

Policy Number: _____ Expiration Date: _____

Amount of Malpractice Coverage: _____

Have malpractice suits been files against you or any action pending? Yes _____ No _____
If yes, please explain: _____

LICENSING/CERTIFICATION

State of: _____ License Number: _____

Expiration Date: _____

In what other states (including D.C.) and countries do you hold or have you held a license to practice? (If any of these licenses are valid, please give license numbers and expiration dates.)

_____

_____

State/Country _____ License Number _____ Expiration Date _____

Certification
Organization: _____ Expiration Date _____

PLEASE GIVE COMPLETE ADDRESSES AND DATES

College or University: _____

Address: _____

Degree: _____ Date of Graduation: _____

Postgraduate
Institution: _____ Date of Completion: _____

Address: _____ Degree: _____

Professional or
Technical: _____ Date of Completion: _____

Address: _____ Degree: _____

This request is in no way to be considered as an application to practice medicine at the Center. If my application is approved, I may only assist my responsible sponsoring physician(s) under his direction and within scope of my license and/or certification.

I hereby certify that I have no physical or mental impairments that will interfere with my performance of the procedures indicated and that I have read and further agree to abide by the Rules, Regulations, and Bylaws of the Medical Staff. I further certify that answers to all questions appearing on this application are correct, to the best of my knowledge.

_____ _____
Signature of Applicant Date

I sponsor this applicant to assist me at the Surgery Center within the limits as delineated. The aforementioned individual is my employee and is included within the coverage provided by my professional liability insurance or has his/her own coverage when performing such duties.

_____ _____
Signature of Sponsoring Physician Date

PLEASE INCLUDE A COPY OF THE MALPRACTICE BINDER FACE SHEET AND LICENSE IF APPLICABLE

Applicant must also complete Acknowledgment and Release form and Disclosure form.

ACKNOWLEDGMENT AND RELEASE AUTHORIZATION

I understand that the Medical Staff of this Center is responsible for the evaluation of my professional competence and qualifications and has the obligation to inquire into my professional training, experience, professional conduct and judgment and to make appropriate recommendations to the governing body of this Center.

By filing an application for privileges, I acknowledge that I have received and read the Bylaws of the Medical Staff and that I am familiar with the principles of medical ethics of the organization applicable to my profession such as the American Medical Association, American Podiatric Association, American Dental Association or American Osteopathic Association and I agree to be bound by the terms thereof without regard to whether or not I am appointed to the Medical Staff.

I agree that it is my duty and ethical responsibility to cooperate with and assist the Medical Staff in evaluating not only my professional qualifications but also those of my colleagues. I agree to appear before Medical Staff officers and committees for interviews or inquiries at reasonable times and places. I consent to the communication of information and documents between this Medical Staff, other Medical Staffs, medical schools, training programs, medical societies, professional associations, professional liability insurance companies and licensing authorities in jurisdictions in which I have trained, resided, or practiced, for the evaluation of my professional training, experience, character, conduct and judgment.

I release from liability all representatives of the Center and its Medical Staff for their acts performed in good faith and without malice concerning my competence and ethical aspects of my professional practice, character, health and emotional status, and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

I agree to notify the Center with any circumstances that would change my status in licensure, DEA, Medicare participation, liability coverage, Board certification or hospital privileges. I affirm that I am physically, mentally and emotionally able to carry out the duties of my practice and perform the procedures I have requested with this application. I hereby affirm that the information furnished by me to the Staff is true to the best of my knowledge and is furnished in good faith. I understand that willful and substantial omissions or misrepresentations may result in denial, modification or revocation of my Medical Staff membership or appointment and/or clinical privileges without the right of appeal. I acknowledge that if I am unfamiliar with a piece of equipment/device and/or believe that I require additional information to safely operate the equipment/device, I will be responsible for seeking in-service and/or training from the appropriate individuals or organizations.

I agree to be bound by the Center's Bylaws, rules and regulations of the Medical Staff and the rules, regulations and policies of the facility.

I authorize any health care facility to release to the Center copies of credentials documents that contain the following information:

The delineation of privileges granted by that health care facility.
My present status on the Medical Staff or Allied Health Professional Staff.
Any disciplinary action that has been taken regarding my privileges or appointment.

I DO HEREBY MAKE FORMAL APPLICATION FOR PRIVILEGES.

Signature: _____ Date:_____

Printed Name:_____

DISCLOSURE
COMPLETED BY ALL APPLICANTS AT INITIAL APPOINTMENT AND AT REAPPOINTMENT

If the answer is **Yes** to any of the following, please provide details on a separate sheet of paper.		Yes	No
1.	Has your license to practice medicine or any other health profession and/or your federal or state registration or permit to prescribe narcotics or other drugs in any jurisdiction ever been voluntarily or involuntarily denied, restricted, limited, suspended, revoked or not renewed, or any currently pending challenges thereof?		
2.	Have you ever voluntarily withdrawn an application, surrendered or not renewed your license to practice medicine or any other profession in any jurisdiction?		
3.	Have you ever been formally charged by, received a reprimand from or been placed on probation by a professional licensing or disciplinary authority of any jurisdiction?		
4.	To the best of your knowledge, are you currently, or within the last 5 years, have you been the subject of a complaint or investigation by a professional licensing/disciplinary agency, a peer review or quality assurance committee at a licensed facility or a professional or specialty society in any jurisdiction?		
5.	Have you ever been involuntarily terminated or been forced to resign from a clinical position with the armed forces or any federal, state or local agency, or any other professional employment or practice arrangement, or have you ever resigned voluntarily while under investigation or threat of sanction?		
6.	Have you ever voluntarily accepted any sanctions or restrictions on your ability to practice under threat of same or voluntarily resigned under threat of same from any of those entities listed in the preceding question?		
7.	Have you ever been reprimanded, censured, or otherwise disciplined by a certifying, registering or licensing agency, a professional or specialty society, a medical staff or a licensed facility?		
8.	Has your request for specific clinical privileges or medical staff membership with a licensed facility ever been denied or granted with stated limitation, or have any of your privileges been voluntarily or involuntarily suspended, revoked, surrendered, withdrawn or not renewed at a licensed facility?		
9.	Have you ever been denied membership in a professional or specialty society?		
10.	Have you ever been convicted of any felony or any misdemeanor involving drugs, alcohol, or in any way the practice of medicine or any other health profession or do you now have such charges pending against you?		
11.	Have you ever been subjected to civil or criminal penalties under the Medicare or Medicaid program?		
12.	Have you ever been suspended from participation in Medicare or Medicaid?		
13.	In the time since you began practicing medicine, have there been any gaps or periods that you were not practicing medicine?		
14.	Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?		
15.	Is there any reason you are unable to perform all the procedures for which you requested privileges, with or without accommodation, according to accepted standards of professional performance without posing a threat to patients, nursing staff, administrative staff or other medical staff?		
16.	Are you currently engaged in illegal use of any legal or illegal substances?		
17.	Do you have any physical, mental, or emotional condition that would affect your clinical performance and judgment in any way?		
18.	Are you currently under any limitations in terms of activity or work load?		
19.	Has your professional liability insurance coverage ever been terminated by action of an insurance company?		
20.	During the past four (4) years, have you been named in or the subject of any malpractice suits?		

Signed_____ Date_____

Print Name_____

AESTHEX PLASTIC SURGERY DOP

PRIVILEGES:	Requested	Recommended	Approved	Denied
Evaluation and diagnosis of medical conditions to determine need for surgical intervention				
BREAST				
Augmentation mammoplasty				
Reduction mammoplasty				
Mastopexy				
Mastectomy – partial or complete				
Incision and drainage of abscess				
Excision of cyst or tumor				
Insertion of tissue expanders				
Biopsy of breast				
Excision of Gynecomastia				
EYE				
Blepharoplasty				
Transconjunctival biopsy of eyelid				
Excision of lesion				
FACIAL				
Nasal fractures, simple				
Nasal fractures, open reduction				
Maxillary – mandibular fractures				
Rhinoplasty				
Rhytidectomy				
Laser facial resurfacing				
Microdermabrasion				
MOHS repair				
Botox injections				
Tattooing				
Brow lift				
Chin augmentation				
Cheiloplasty				
HEAD & NECK				
Cleft lip repair				
Cleft palate repair				
Excision of lesion				
Otoplasty				
SKIN & SUBCUTANEOUS TISSUE				
Biopsy				
Burn treatment – debridement				
Laceration repair				
Liposuction				
Skin graft				
Suture repair				
Scar revision				
HAND				
Carpal tunnel procedures				
DeQuervain's release				
Peripheral nerve repair				
Plastic repair with tissue graft or prosthetic implant				
Reimplantation of extremities				
Suture – muscle, tendon, fascia				
Transplantation of muscle, tendon				
GENERAL				
Gender re-assignment				
Hypospadias repair				
Penile implant				
Tissue expanders and implants				
Laser				
CO2				
Erbium				
Imaging				
Use imaging during procedure (radiographic, fluoroscopy/C-arm, ultrasonic, or other services) and interpretation of image during procedure				

Anesthesia				
Local Anesthesia				
Moderate Sedation (only request if you intend to administer – must complete separate form and be ACLS certified)				
Supervision of CRNA				
Supervision of RN for Conscious Sedation				
Pediatrics				
Adults				
Other:				

Applicant's initials as used on documents/records _____

Applicant's signature as used on documents/records _____

Applicant Signature: _____ Date: _____

Recommendations and Approvals

Recommendation: Medical Director Signature: _____ Date: _____

Recommendation: Medical Advisory Committee: Signature of Chair: _____ Date: _____

Approval: Governing Body Signature of Chair: _____ Date: _____

AESTHETX

CERTIFICATION OF COVID 19 VACCINATION STATUS

NAME: _____ DATE OF BIRTH: ___

Per CDPH Guidance for Vaccine Records Guidelines & Standards, all Health Care Personnel are required to provide vaccination status to Ambulatory Surgery Centers in the State of California.

Proof of vaccination is required by all HCP working at AX Surgery Center.

Please select the statement(s) that most accurately describes your **vaccination status**:

- ☐ I received my (2) dose primary vaccination series with either Pfizer, Moderna, or Johnson & Johnson.
- ☐ I received a Bivalent booster dose from either Pfizer or Moderna on: _____ (please provide record)
- ☐ I am up to date with my most recent **Omicron booster** from either Pfizer, Moderna, or Novavax on: _____ (please provide record)
- ☐ I have not been vaccinated, but have an appointment scheduled on (insert date) _____
- ☐ I have not been vaccinated but have a medical or religious exemption form on file with surgery center.
  - □ I am also declining the Omicron booster.
- ☐ I plan to receive the Omicron booster and have an appointment scheduled on (insert date) _____
- ☐ I am declining the **Omicron booster**.

_____ _____

Employee Signature **Date**

_____

Employee Printed Name