



HARMONEX

APPLICATION FOR APPOINTMENT TO THE OFFICE STAFF

Status Requested: **INSURANCE SPECIALIST** **RECEPTION** **MANAGEMENT**

A. Personal Information

Name in Full _____ Social Security Number _____

Office Address: Number and Street _____ City _____ State _____ Zip _____

Home Address: Number and Street _____ City _____ State _____ Zip _____

Telephone: _____ Office _____ Residence _____

Date of Birth _____ Place of Birth _____ Citizenship _____

Contact in Case of Emergency:

Name _____ Relationship _____

Address _____ Telephone _____

B. Education

	School Name & Location	Major	Degrees Awarded	Dates Attended	Graduation Date
1. UNDERGRADUATE	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
2. GRADUATE	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
3. POST GRADUATE	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

C. References

Name at least three professionals who have personal knowledge of your current employment qualifications, ethical character, health status, and ability to work cooperatively with others and who will provides specific written comments on these matters upon request from Medical Services authorities. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time and, at least one, must have had organizational responsibility for your performance. Preferably, the individuals should not be related to you by family or recently initiated or impending professional partnership/financial association.

Name

Address

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

CONDITIONS OF APPLICATION:

By applying for appointment to Harmonex, Inc.
I hereby:

Signify my willingness to appear for interviews in regard to my application;

Authorize Harmonex, its Administration, Medical Staff and their representatives to consult with my prior and current associates and other who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges I request;

Consent to the inspection by the Administration, its Medical Staff and their representatives of all documents that may be material to an evaluation of my qualifications and competence;

Consent to the release of such information;

Release from liability all representatives of Harmonex, Inc. and its Staff for their acts performed and statements made in good faith and without malice in connection with evaluating my application and my credentials and qualifications;

Release from liability any and all individuals and organizations who provide information to Harmonex, Inc. or the Medical Staff, in good faith and without malice concerning my professional competence, ethics, character and other qualifications for Staff appointment and clinical privileges;

Acknowledge that upon appointment to the medical staff, I will be given access to and will read the Harmonex Policy & Procedure manual and any other manuals and policies relevant to the application process and generally relating to Staff membership and clinical privileges and to the consideration of my application for appointment to the Staff and for clinical privileges;

Acknowledge that the provisions of said Harmonex Corporate Staff Bylaws relating to the confidentiality and release from liability are express conditions to my application for, and acceptance of, Staff membership and the continuation of such membership and my exercise of clinical privileges;

Pledge to maintain an ethical practice, to provide for continuous care for my patients and to refrain from delegating the responsibility for any aspect of the care of my patients to any practitioner not qualified to undertake that responsibility;

Agree to keep Harmonex, Inc. representatives informed of any change made proposed in the status of my professional license to practice, DEA or other controlled substances registration, malpractice insurance coverage, and membership or clinical privileges at other institutions, and on the status of current or initiation of new malpractice claims;

Acknowledge that I am an applicant for Harmonex Network Physician Membership and Privileges, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications for membership and clinical privileges and for resolving any doubts about such qualifications and acknowledge that any significant misstatements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the Medical Staff.

All information submitted by me in this application is true and complete to my best knowledge and belief.

Date

Signature

Harmonex, Inc. will treat this application and any information secured in connection therewith in confidence and will employ all reasonable safeguards to prevent the unauthorized disclosure of any such information.