KIDSHEALTHFIRST
PEDIATRIC ALLIANCE

Quality – Care – Innovation...FIRST

Pre-Hire Screening

Practices participating in the KHF-MP are required to have Providers screened before an offer is made.

1. Provider must sign the Scheduled A (this is to pull the NPDB) Authorization Form and Release of Information Form
2. Provider must complete and sign the Background Check Release Form
3. Provider must complete and sign the Malpractice Application*
4. Complete CV showing entire education and job history to the present
5. Practice must return the completed Malpractice Application, Credentialing Authorization Release Form, CV/Resume and Background Check Release Form to the KHF-MP representative.

*This Application *MUST* be filled out for malpractice. This does not mean you made the applicant an offer nor will they be put on your Policy, unless the applicant comes back *CLEAR,* and you have hired them.

To ensure Quality and Risk Management even further, the Board recommends that Practices perform a drug screening as well

Kids Health First

New Data Pull Authorization Form

☐ **Physician** ☐ **NP** ☐ **Physician Assistant**

Practice Requesting Data: _____

Anticipated/Actual Start Date: _____

Required Information

Full Name: _____

Maiden Name if different from above: _____

Date of Birth:_____ Social Security #: _____

NPI #:_____ MD GA Medical License #: _____

NP/PA License #: _____ CAQH#: _____

Gender:_____ Full-time (3+ more days per week): _____ Part-time (2-days or less per week):_____

Email: _____@_____

Are there any licensing or malpractice concerns that we should be aware of?
____ Yes, (please provide additional information below) ____ No

_____
_____
_____

Home Address:
_____
_____

***Note: Please print legibly**

Revised: February 16, 2024

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this Application, including all subparts and attachments, I acknowledge, understand, consent, and agree to the following:

8. I release from any liability, to the fullest extent permitted by law, all persons and entities (individuals and organizations) for their acts performed in a reasonable manner in conjunction with investigating and evaluating my Application and Qualifications, and I waive all legal claims of whatever nature against the Healthcare Entity and its representatives and designated agents acting in good faith and without malice in connection with the investigation of this Application and my Qualifications.

9. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations, and policies. I agree to conduct my practice in accordance with applicable laws and ethical principles of my profession. I also agree to provide for continuous care for my patients.

10. Any investigations, actions or recommendations of any committee or the governing body of the Healthcare Entity with respect to the evaluation of this Application and any periodic reappraisals or evaluations will be undertaken as a medical review and/or peer review committee and in fulfillment of the Healthcare Entity's obligations under Georgia law to conduct a review of professional practices in the facility and are therefore entitled to any protections provided by law.

11. I have read and understand this Authorization and Release of Information Form. A photocopy of this Authorization and Release of Information Form shall be as effective as the original and shall constitute my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this Application. This Authorization and Release shall apply in connection with the evaluation and processing of this Application as well as in connection with any periodic reappraisals and evaluations undertaken. I agree to execute such additional releases as may be required from time to time in connection with such periodic reappraisals and evaluations.

Signature:	
Printed Name:	**Date:**

I grant permission for the release of the credentials information contained in this Application to the following Healthcare Entity(ies):

_____

_____

_____

ACKNOWLEDGMENT AND AUTHORIZATION FORM FOR BACKGROUND SCREENING

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT -Summary of your rights can be obtained from the following link: (http://www.ftc.gov/bcp/edu/pubs/consumer/credit/cre35.pdf) and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and, if I am hired, throughout my employment. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by S2Verify, LLC 912 Holcomb Bridge Road, Suite 301, Roswell, GA 30076 phone: 678-608-2771, fax: 770-200-1595, another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original. Minnesota and Oklahoma applicants or employees only: Please check the box on the following page if you would like to receive a copy of a consumer report if one is obtained by the Company. California applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check the box below if you would like to receive a copy of an investigative consumer report if one is obtained by the Company at no charge whenever you have a right to receive such a copy under California law. I understand that I have specific prescribed rights as a consumer under the federal Fair Credit Reporting Act ('FCRA') and may have additional rights under relevant state law.

_____ _____

Signature of Applicant Date

_____

Printed Name

_____Date of birth

_____Social Security number

_____Driver’s license number # and State of issue

_____Address

_____City, State, Zip

Applicant Information

Minnesota Oklahoma or California Residence, if you would like a free copy of your consumer report (Background Check) please click the box

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