

**APPLICATION FOR INITIAL APPOINTMENT
FACT INSPECTOR**

1. All information should be printed or typed.
2. If more space is needed, attach additional sheets and make reference to the question being answered.
3. Please attach copies of the following documents to this application:
 - a) Current license to practice medicine in the area where you practice: state, country, province, etc.
 - b) Current DEA narcotics registration certificate
 - c) Professional liability insurance policy certificate from insurance carrier (if applicable)
 - d) ECFMG certificate (if foreign medical graduate and applicable)
 - e) Evidence of board certification or eligibility status (as applicable and to the area where you practice)
 - f) A curriculum vitae
 - g) One wallet-size black and white or color photographs.

I. PERSONAL IDENTIFICATION DATA

Date of Application: _____

Last Name _____ First _____ MI _____ Suffix _____

Birth date _____ Birthplace _____ Birth Name _____

Citizenship/Nationality _____ Social Security/UPIN# _____

Residence Address _____

Telephone _____

Name of Cord Blood Bank, Cellular Therapy program, collection facility, or cell processing laboratory with which you are affiliated:

Is your program, facility, laboratory, or Cord Blood Bank FACT accredited or in the process of FACT Accreditation?

Yes _____ No _____

If no, has your facility applied for on-site inspection?

Yes _____ No _____

If no, are you affiliated with a facility that is FACT accredited or in the process of FACT accreditation?

Yes _____ No _____

Office Address _____

Telephone _____ E-mail _____

Fax _____ Answering Service (phone) _____

Pager # _____ Mobile Phone _____

If you are expecting an office address change in the near future, please complete the following:

New Office Address _____ Telephone _____

Association/Group _____ Expected date of change _____

If not a citizen of the United States, please indicate the status of your visa at the present time (if applicable)

What language(s) do you speak and/or read? _____

II. PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____ Relationship _____

Address _____ Telephone _____

III. CTP OR CBB EXPERIENCE

- A. Are you a member of ISCT? Yes _____ No _____
- Are you a member of ISCT-Europe? Yes _____ No _____
- Are you a member of EBMT? Yes _____ No _____
- Are you a member of ASBMT? Yes _____ No _____
- Are you a member of NetCord? Yes _____ No _____
- Are you a member of ASFA? Yes _____ No _____
- Are you an Inspector for JACIE? Yes _____ No _____

B. Are you qualified to be an inspector as defined in the policies of FACT? Yes _____ No _____

C. Under the FACT Standards, would you be qualified to be a Director as defined in the Standards?

Yes _____ No _____

If so, are you qualified to be a

- CTP Program Director? Yes _____ No _____
- CTP Laboratory Medical Director? Yes _____ No _____
- CTP Laboratory Director? Yes _____ No _____
- CTP Collection Facility Medical Director? Yes _____ No _____
- CBB Director? Yes _____ No _____
- CBB Medical Director? Yes _____ No _____
- CBB Laboratory Director? Yes _____ No _____
- CBB Collection Facility Medical Director? Yes _____ No _____

D. Have you read and do you fully understand the FACT Standards? Yes _____ No _____

E. Number of years you have been actively involved in clinical cellular therapy programs, collection services, and/or processing laboratories: _____

F. Describe the nature of your experience with CTP or CBB: _____

G. Give a specific description of your current practice with respect to CTP or CBB: _____

H. How many inspections are you willing to perform each year? _____

IV. EDUCATIONAL DATA

A. Schools

Undergraduate College or University	Dates <u>Attended</u>	Degree <u>Awarded</u>	Date of <u>Graduation</u>
_____	_____	_____	_____

Complete Address _____

Medical/Dental/Podiatric College _____

Complete Address _____

Other Professional Training _____

Complete Address _____

B. Internship

<u>Institution</u>	Type of <u>Internship</u>	Dates <u>From:</u>	<u>To:</u>
_____	_____	_____	_____

Complete Address _____

Program Director _____

(If more than one internship was begun or completed, please supply the same information on a separate sheet and attach.)

C. Residencies

	<u>Institution</u>	<u>Department Chairperson</u>	<u>Type of Residency</u>	<u>Dates From:</u>	<u>To:</u>
1)	_____	_____	_____	_____	_____
	Name				

	Complete Address				
2)	_____	_____	_____	_____	_____
	Name				

	Complete Address				

(If more than two residencies were begun or completed, please supply the same information on a separate sheet and attach.)

D. Fellowship

	<u>Institution</u>	<u>Department Chairperson</u>	<u>Type of Residency</u>	<u>Dates From:</u>	<u>To:</u>
1)	_____	_____	_____	_____	_____
	Name				

	Complete Address				
2)	_____	_____	_____	_____	_____
	Name				

	Complete Address				

(If more than two fellowships were begun or completed, please supply the same information on a separate sheet and attach.)

E. Teaching Appointments

	<u>Institution</u>	<u>Department Chief</u>	<u>Type of Appointment</u>	<u>Dates From:</u>	<u>To:</u>
	_____	_____	_____	_____	_____
	Name				

	Complete Address				

(If more than one teaching appointment was begun or completed, please supply the same information on a separate sheet & attach.)

F. Post-Graduate and Continuing Education Courses (During the past two years)

	<u>Institution</u>	<u>Dates From:</u>	<u>To:</u>
1)	_____	_____	_____
	Name		

	Complete Address		
2)	_____	_____	_____
	Name		

	Complete Address		

(If more space is needed, please attach separate sheet.)

G. Licensure/Registrations

Medical/Osteopathic/Dental/Podiatric License: (List all current and past and specify the type, i.e., M.D., D.O., DDS, DSc, etc. Indicate any restrictions on any current or prior license.)

Locality	Type	Number	Year issued	Date expires
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

H. Current Controlled Substances Registrations (if applicable)

Federal # _____ Issued _____ Expires _____
State # _____ Issued _____ Expires _____

I. During your training, were you every suspended, placed on probation, formally reprimanded, or asked to resign?
Yes _____ No _____

If the answer to the question is yes, please provide full explanation of the details on a separate sheet, and attach.

V. PROFESSIONAL PRACTICE (Current and Previous in Chronological Order)

Dates From: _____ To: _____ Nature of Practice _____
(Solo, partnership, group, HMO, RA, PPA)
Name _____
Address _____

Dates From: _____ To: _____ Nature of Practice _____
(Solo, partnership, group, HMO, RA, PPA)
Name _____
Address _____

Dates From: _____ To: _____ Nature of Practice _____
(Solo, partnership, group, HMO, RA, PPA)
Name _____
Address _____

VI. INSTITUTIONAL AFFILIATIONS

- A. List in chronological order all institutions affiliations since completion of post-graduate education. This includes all hospitals, corporations, military assignments, or government agencies. Complete addresses must be included. If more space is needed, attach additional sheet.

<u>Institution</u>	<u>Department Service</u>	<u>Staff Category</u>	<u>Department Chairperson</u>	<u>Dates From:</u>	<u>To:</u>
1) _____	_____	_____	_____	_____ - _____	_____

Complete Address _____

2) _____	_____	_____	_____	_____ - _____	_____
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Complete Address _____

3) _____	_____	_____	_____	_____ - _____	_____
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Complete Address _____

4) _____	_____	_____	_____	_____ - _____	_____
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Complete Address _____

- B. Has your employment, medical staff appointment, or clinical privileges ever been voluntarily or involuntarily suspended, denied, diminished, revoked, refused, or limited at any hospital or other health care facility?
 Yes _____ No _____
- C. Have you ever withdrawn your application for appointment, reappointment, and clinical privileges or resigned from the medical staff before a decision was made by a hospital's or health care facility's governing board?
 Yes _____ No _____
- D. Have you ever been the subject of disciplinary proceedings at any hospital or health care facility?
 Yes _____ No _____

If the answer to B, C, or D is yes, please provide a full explanation of the details on a separate sheet of paper.

VII. PROFESSIONAL ASSOCIATIONS

A. Membership in Professional Societies (local, state, or national). Attach additional pages as needed.

1. <u>Society Name & Address</u>	Dates		Membership <u>Status</u>
	<u>From:</u>	<u>To:</u>	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceeding in any professional organization? Yes _____ No _____

If yes, please provide full explanation of the details on separate sheet, and attach.

B. Board Status

Name of specialty boards by which you are certified:	Date <u>Certified</u>	Date <u>Recertified</u>	Qualified <u>(Until When)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

VIII. PROFESSIONAL LIABILITY DATA

A. Insurance

1. Has your professional liability insurance coverage ever been terminated by action of the insurance company?
Yes _____ No _____

2. Have you ever been denied professional liability insurance coverage?
Yes _____ No _____

3. If the answer to question 1 or 2 above is yes, state when and by what company:

4. Has your present professional liability insurance carrier excluded any specific procedures from your coverage?
Yes _____ No _____

5. If the answer to question 4 above is yes, list the procedures which have been excluded and provide a full explanation on a separate sheet, including the name of the carrier, the date, and specific information concerning any limitation.

Present Carrier:

Name _____

Address, City, State, and Zip _____

Agent, Address, Telephone Number _____

Expiration Date (Month/Day/Year) _____

Type of Policy _____

Prior Carriers:

Name	Address	Policy#	Coverage Period
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_____	_____	_____	_____
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Name	Address	Policy#	Coverage Period
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_____	_____	_____	_____
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Name	Address	Policy#	Coverage Period
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_____	_____	_____	_____
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B. Legal Actions

1. Have any professional liability suits ever been filed against you?

Yes _____ No _____

2. Have any professional liability suites been filed against you that are presently pending?

Yes _____ No _____

3. Have any judgments or settlements been made against you in professional liability cases?

Yes _____ No _____

(If the answer to any of the above questions is yes, please provide a full explanation of the details on an attached sheet.)

C. Disciplinary Actions

Have any of the following ever been, or are any currently in the process of being investigated, denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished, or have you ever withdrawn or failed to proceed with an application for any of the following? If yes, please provide full explanation on a separate sheet.

	Yes	No
Medical license in any locality	_____	_____
Other health-related professional registration/license	_____	_____
DEA/controlled substance registration	_____	_____
Academic appointment	_____	_____
Membership on any hospital medical staff	_____	_____
Clinical privileges at any hospital	_____	_____
Prerogatives/rights on any medical staff	_____	_____
Other institutional affiliation, status or privileges	_____	_____
Health-related professional society membership or fellowship/Board certification	_____	_____
Any other type of professional sanction	_____	_____
Have you ever been convicted of or pleaded no contest to any criminal charges (other than motor vehicle speeding violations) brought against you?	_____	_____
(If yes, provide full explanation on separate sheet, including resolution of charges.)		
Have you ever been convicted or pleaded no contest to a drug or alcohol related offense?	_____	_____
(If yes, please provide full explanation on separate sheet.)		
Have you ever been sanctioned by a PSRO, PRO, or similar federal or state agency?	_____	_____
(If yes, please provide full explanation on separate sheet.)		
Have you ever been excluded from participating in the Medicare or Medicaid Programs, or are there any pending actions that may result in exclusion?	_____	_____
(If yes, please provide full explanation on separate sheet.)		

IX. PROFESSIONAL REFERENCES

A. References

List at least two professional references from persons involved in HPC transplantation, cell processing, or cord blood banking, and one character reference, and any additional references as necessary, excluding relatives. Provide current, complete addresses. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you.

1. Name _____ Telephone _____

Address _____

2. Name _____ Telephone _____

Address _____

3. Name _____ Telephone _____

Address _____

APPLICATION, REPRESENTATIONS, CONSENT AND RELEASE

I hereby apply for appointment as an inspector for FACT.

Representations and Warranties

By applying for an appointment as a FACT inspector, I represent and warrant that all information submitted by me in or in connection with this application is true and complete to the best of my knowledge and belief. Further,

1. I agree to abide by the policies, procedures and Standards of FACT, as may be enacted from time to time.
2. I agree to respect all confidences and abide by all laws and regulations as well as FACT policies and procedures related to confidential information.
3. I agree to voluntarily withdraw from any inspection assignment in which I may have a conflict of interest, and I agree to participate according to all professional and ethical standards of my specialty and profession.
4. I agree that it is my responsibility to provide the above information to the FACT Office. I acknowledge that failure to provide such information may be grounds for non-appointment.
5. I agree to notify the FACT Office immediately if there are any significant changes to any of the above information (including, but not limited to, a change in the status of my professional license to practice, my DEA controlled substances registration, my professional liability insurance coverage, or my membership, employment, or clinical privileges at other health care institutions or organizations and of changes in or the initiation of professional liability claims or lawsuits).
6. I fully understand that any misstatements or misrepresentations in or omissions from this application are cause for denial of appointment as an inspector.
7. I acknowledge that my request will be evaluated in accordance with prescribed procedures defined in the FACT bylaws, Standards, policies and procedures as approved by the FACT Board of Directors.
8. I acknowledge that it is my responsibility to keep this application current by informing the FACT Office of any change in the areas of inquiry contained herein and to provide such additional information as may be requested.
9. Appointment as an inspector remains contingent upon my continued demonstration of professional competence and cooperation. Appointment shall be granted only on formal application, completion of initial inspector training, and approval of the FACT Board of Directors.
10. All decisions relative to this application are subject to the ultimate action of the FACT Board of Directors, whose decision shall be final.

Consent to Release of Information

By applying for appointment as a FACT inspector, I hereby:

1. Signify my willingness to appear for interviews regarding my application;
2. Authorize FACT Board members to consult with administrators, employees and members of medical staffs of other hospitals or organizations with which I have been associated with respect to my professional competence, character and ethical qualification;
3. Consent to FACT Board of Directors' inspection of records and documents which may be material to an evaluation of my professional competence and my professional, moral and ethical qualifications for clinical privileges and staff membership;
4. Authorize the FACT Board of Directors to release information regarding my qualifications and performance to hospitals, medical associations and other appropriate persons upon their legitimate request, and I hereby consent to the release of such information.

Release of Liability

By applying for appointment, I accept the following conditions during the processing and consideration of my application, regardless whether I am granted appointment, and for the duration of such appointment or reappointments as I may be granted:

Definitions

The term "FACT Board" means the Board of Directors of the Foundation for the Accreditation of Cellular Therapy and any of the individuals who may be designated the responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct during the inspection. The term "third parties" means all individuals from whom information has been requested by the FACT Board or its authorized representatives or who have requested such information from the FACT Board and its authorized representatives.

I extend immunity to, and release from any and all liability, the FACT Board, its authorized representatives, and any third parties, as defined above, for any professional review actions, communications, reports, records, statements, documents, recommendations, or disclosures involving me, performed, made, requested, or received by FACT and its authorized representatives to, from, or by any third party, including otherwise privileged or confidential information, relating, but not limited to, the following:

- a) Applications for appointment or clinical privileges, including temporary privileges;
- b) Periodic reappraisals undertaken for appointment or for increase or decrease in clinical privileges;
- c) Matters or inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or behavior;
- d) Any other matter that might directly or indirectly have an effect on my competence to be an inspector.

The foregoing shall be privileged to the fullest extent permitted by law. Such privilege shall extend to the FACT Board, its authorized representatives, and to any third parties.

Signed: _____ Date: _____

Witness: _____

PROFESSIONAL LIABILITY CLAIM/SUIT INFORMATION

If you are or have been involved in a professional malpractice suit or written claim, please supply the following information. If more than one claim/suit exists, please photocopy this page and submit information on each claim/suit. A full disclosure of the following details is necessary prior to completion of credentialing, and all information will be kept in confidence.

1. Date of Occurrence:

2. Who is (was) the involved insurance carrier?

3. Please provide detailed specifics about the event.

4. What is (was) your role in the event?

5. What is (was) your status?

Primary Defendant _____ Co-defendant _____
Other _____

6. Current Status of Claim/Suit:

7. Amount reserved by carrier for this claim/suit (if unknown, please inquire of your carrier):

8. Style of Suit: _____

9. Court in which Filed: _____