Application for Membership

Application Summary

Applying organization / AF center name:

Parent organization name if applicable:

Application Checklist
A complete application will include the following items:

- ❑ Cover letter (optional)
- ❑ Completed "application summary" (this form)
- ❑ Program description (description of the program including care philosophy, multi-disciplinary clinic structure including methods and frequency of collaboration, background, research and publications, forward-looking vision, etc)
- ❑ Organizational chart demonstrating governance
- ❑ Organizational chart demonstrating department, center and/or clinic staffing
- ❑ Physician biography and CV for participating electrophysiologists (EP) and cardiothoracic surgeons
- ❑ Three-year volume trends – (a) Open standalone MAZE, (b) Concomitant MAZE, (c) Thoracoscopic MAZE, (d) Catheter ablation
- ❑ Three-year ratio of concomitant MAZE procedures to total CT surgical patients with AF diagnosis
- ❑ Promotional materials (website address, dedicated call-in number, brochures, videos, patient education manual, etc)
- ❑ Completed peer-to-peer interview with NAIAC board member. (The interview should include participation of an EP and a surgeon representing the organization. Contact NAIAC to schedule)
- ❑ Letters of recommendation from NAIAC members or industry partners (optional)
- ❑ Letter of intent to join NAIAC, participate in data collection requirements, and to pay annual dues ($10,000/year as of 2015) from an authorized party of the center or an appropriate parent organization
- ❑ Non-refundable application fee of $500 (if membership is approved this fee will be applied to first year membership dues)

Contact information

Applicant organization address:
Organization Name:
Contact:
Phone:
Alternate phone:
Email:
Website:
Address:
City:
State:
ZIP:

Parent organization address (if different):
Organization Name:
Contact:
Phone:
Alternate phone:
Email:
Website:
Address:
City:
State:
ZIP:

Clinic or alternate address:
Clinic Name:
Contact:
Phone:
Alternate phone:
Email:
Website:
Address:
City:
State:
ZIP:

Please answer the following questions on behalf of the organizations listed above. Please attach a written explanation for each affirmative response:

Yes **No**

❑ ❑ Have any of the listed organizations' accreditations or certifications or CMS participation been limited, voluntarily surrendered, suspended or revoked in the last ten years?

❑ ❑ Have any of the listed organizations ever had an application for membership in any medical or specialty society rejected?

Participating Physicians (must include at least one electrophysiologist and one cardiothoracic surgeon):

Physician #1
Name:
Specialty:
Sub-specialty:
Phone:
Email:
❑ CV attached

Physician #2
Name:
Specialty:
Sub-specialty:
Phone:
Email:
❑ CV attached

Physician #3
Name:
Specialty:
Sub-specialty:
Phone:
Email:
❑ CV attached

Physician #4
Name:
Specialty:
Sub-specialty:
Phone:
Email:
❑ CV attached

Please answer the following questions on behalf of the physicians listed above and indicate to which physician(s) each affirmative response applies. Please attach a written explanation for each affirmative response:

Yes No

❑ ❑ Have any of the listed physicians been convicted of a felony crime related to medical practice within the last 5 years? If yes, which physician(s): ________

❑ ❑ Have any of the listed physicians' license to practice medicine in any jurisdiction ever been limited, voluntarily surrendered, suspended or revoked? If yes, which physician(s): ________

❑ ❑ Have any of the listed physicians ever been the subject of any disciplinary action by any medical society, specialty society or hospital staff? If yes, which physician(s): ________

❑ ❑ Have any settlements or judgments of malpractice claims been paid by you or on your behalf by another entity? If yes, which physician(s): ________

❑ ❑ Have any of the listed physicians ever had an application for membership in any medical or specialty society rejected? If yes, which physician(s): ________

Attestations

If accepted as a member, I agree to notify the National Alliance of Integrated Afib Centers (NAIAC) of any changes in medical or clinical staffing or status of this organization which may impact its standing as a member as defined by the most current "Criteria for Membership" at the time of such a change. I furthermore understand that such a change may be reviewed by the NAIAC membership committee and that membership may be suspended or revoked at any time if I am found to be out of compliance with the criteria for membership. I hereby release, and hold harmless, from any liability or loss including attorney fees, the National Alliance of Integrated Afib Centers (NAIAC) its members, officers, agents and employees for acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications, and hereby release from any liability any and all individuals and organizations who, in good faith and without malice, provide information to the above named organizations, or their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership. All information submitted in this application is true to the best of my knowledge and belief. I understand that any significant misstatement in, or omissions from, this application may constitute cause for denial of membership. Furthermore I hereby attest that I am authorized to sign this application and commit to the requirements of membership on behalf of the applicant and its parent organization.

Signature: ______________________________

Title: ______________________________

Organization: ______________________________

Date: ______________________________

Please e-mail this completed application to: NAIAC attention Joshua Cowan at JCowan@naiac.org or submit by mail to:

NAIAC
Attention: Joshua Cowan
790 Chiles Ave.
Saint Helena, CA 94574