



Application for Appointment to the Medical Staff

Hospital _____

Location _____

Today's Date _____

APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

General Instructions: Application must be typed or legibly printed in ink. Where requested, and when there is sufficient space to complete your response, attach additional sheets.

IDENTIFYING INFORMATION	Last Name		First Name		Middle	Social Security No.		
	Residence Address			City	State	Zip	Telephone ()	
	Office Address			City	State	Zip	Telephone ()	
	Citizenship		E.C.F.M.G. No./Date Issued			Medicare No.	Telephone ()	
PREMEDICAL INFORMATION	College or University				Degree		Honors	
	Street		City	State	Zip	Date of Graduation		
MEDICAL EDUCATION	Medical School				Degree		Honors	
	Street		City	State	Zip	Date of Graduation		
INTERNSHIP	Medical School							
	Street		City	State	Zip	Dates		
	Type of Internship				Specialty			
	Practitioners Responsible for Performance (Chief of staff, Chairman of Departments, Others)							
LIST IN CHRONOLOGICAL ORDER, IF ADDITIONAL SPACE IS REQUIRED, ATTACH A SEPERATE SHEET								
RESIDENCIES, FELLOWSHIPS, PRECEPTORSHIPS, TEACHING APPOINTMENTS	Facility (Full Name)							
	Street		City	State	Zip	Dates		
	Type			Practitioner(s) Responsible for Performance (Chief of staff, Chairman of Departments, Others)				
	Facility (Full Name)							
	Street		City	State	Zip	Dates		
	Type			Practitioner(s) Responsible for Performance (Chief of staff, Chairman of Departments, Others)				
	Facility (Full Name)							
	Street		City	State	Zip	Dates		
Type			Practitioner(s) Responsible for Performance (Chief of staff, Chairman of Departments, Others)					
CONTINUING MEDICAL EDUCATION	ON A SEPERATE SHEET LIST ALL POSTGRADUATE WORK THAT YOU HAVE ATTENDED OR FOR WHICH YOU HAVE RECEIVED CREDIT IN THE PAST TWENTY-FOUR MONTHS							
	FURNISH A LIST OF SCIENTIFIC PAPERS OR ESSAYS YOU HAVE WRITTEN AND A LIST OF SCIENTIFIC MEETINGS YOU HAVE ATTENDED DURING THE PREVIOUS THREE YEARS INCLUDING REPRINTS							
AFFILIATIONS	LIST ALL PRESENT AND PREVIOUS AFFILIATIONS WITH HEALTH CARE FACILITIES AND MEDICAL STAFF MEMBERSHIPS FOR THE PAST 10 YEARS IN CHRONOLOGICAL ORDER (INCLUDE ASSISTANTSHIPS, APPOINTMENTS AND MILITARY EXPERIENCE), SPECIFY ALL DEPARTMENTS IN WHICH PRIVILEGES WERE EXERCISED AND NATURE AND EXTENT OF SUCH PRIVILEGES.							
	Present capacity with this Hospital					Dates		
	Facility (Full Name)				Capacity	No. of Beds		
	Street		City	State	Zip	Dates	Dates	
	Facility (Full Name)				Capacity	No. of Beds		
	Street		City	State	Zip	Dates	Dates	
	Facility (Full Name)				Capacity	No. of Beds		
	Street		City	State	Zip	Dates	Dates	
Facility (Full Name)				Capacity	No. of Beds			
Street		City	State	Zip	Dates			

DESCRIPTION OF CURRENT PRACTICE	Last Name	
	Practicing With Whom and Nature of Affiliation	
	Other medical interests in practice, Research, Etc	
MEDICAL REFERENCES	Name three individuals who have personal knowledge of your current clinical ability, ethical character, health status, and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from Hospital and Medical Staff 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. None of the individuals should be related to you by family or professional partnership or financial association. (Requested sources: Chief of residency training program, department chairman/service chief, practitioners in same specialty, administrators of prior hospitals).	
	Name and Address	Telephone ()
	Name and Address	Telephone ()
	Name and Address	Telephone ()
	Name and Address	Telephone ()
MEMBERSHIP APPOINTMENT AND PRIVILEGES DESIRED	Department(s)/Section(s) in which you are requesting membership appointment:	
	Please Specify Staff Category Desired: <input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Consulting	
	Special Procedures (Specify)	
	Special or Sub-Specialty Consultation (Specify)	
Privileges Desired:		
<input type="checkbox"/> Active	<input type="checkbox"/> Gynecological	<input type="checkbox"/> Radiological
<input type="checkbox"/> Anesthetic	<input type="checkbox"/> Obstetrical	<input type="checkbox"/> Orthopedic
<input type="checkbox"/> Surgical	<input type="checkbox"/> Pediatric	<input type="checkbox"/> Dental
<input type="checkbox"/> Other (Specify) _____		
REQUEST PRIVILEGES DESIRED BY CHECKING THOSE ON THE FOLLOWING PAGES. WRITE IN, AT THE END OF EACH SECTION, THOSE PRIVILEGES DESIRED THAT ARE NOT LISTED. PLEASE ENCLOSE MATERIALS/INFORMATION NECESSARY TO DOCUMENT YOUR TRAINING AND CAPABILITY IN THOSE AREAS FOR WHICH YOU ARE REQUESTING PRIVILEGES THAT, IN GENERAL, WOULD NOT FALL WITHIN YOUR SPECIALTY OR SUB-SPECIALTY CATEGORY.		
REQ.-Requested	REC.-Recommended	N/R.- Not Recommended

MEMBER IN PROFESSIONAL SOCIETIES	Are you a member of the County Medical Association? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Do you have an application pending? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you intend to apply? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Practicing With Whom and Nature of Affiliation				
FELLOWSHIP	American College of			Date	
	American College of			Date	
CERTIFICATION	Fellowship in Other Specialty Colleges, Academes, or Associations				
	If Board Certified, State Name of Board			Date	
	If Board Admisable Name of Board			Date	
	If Not Certified, Give Present Status				
LICENSING	Medical License (Name of State and County)		Date Issued	Date Expires:	License No.
	Drug Enforcement Administration Renewal Date:	License No.	Controlled Substance Administration Renewal Date:	License No.	
	Other (Nature of License, County and State)		Date Issued	Date Expires:	License No.
LIABILITY INSURANCE	ENCLOSE CERTIFICATE OF PROFESSIONAL LIABILITY INSURANCE DOCUMENTING AMOUNT OF COVERAGE AND EXPIRATION DATE				
	Amount of Coverage	Insurance Carrier		Expiration date	
	Policy No.	Agent (Name and Full Address)			
	Prior Carriers				
	IF EITHER OF THE FOLLOWING IS ANSWERED IN THE AFFIRMATIVE, PROVIDE FULL EXPLANATION ON A SEPERATE SHEET				
	During the past 10 years, have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you ever been denied Professional Liability Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
DISCIPLINARY ACTIONS	HAVE ANY OF THE FOLLOWING EVER BEEN OR ARE CURRENTLY IN THE PROCESS OF BEING DENIED, REVOKED, SUSPENDED REDUCED, LIMITED, PLACED ON PROBATION, NOT RENEWED, OR VOLUNTARILY RELINQUISHED? IF YES, PLEASE PROVIDE FULL EXPLANATION ON A SEPARATE SHEET.				
	Medical license in any state				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Other professional registration/license				<input type="checkbox"/> Yes <input type="checkbox"/> No
	DEA registration				<input type="checkbox"/> Yes <input type="checkbox"/> No
	academic appointment				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Membership in any hospital medical staff				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Clinical privileges				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Prerogatives/rights on any medical staff				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Other institutional affiliation or status there at				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Professional society membership or fellowship/Board certification				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Professional office				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Any other type of professional sanction				<input type="checkbox"/> Yes <input type="checkbox"/> No
Have there been any felony charges brought against you in the last 5 years? If yes, please provide full explanation on a seperate sheet, including resolution of charges.					

APPLICANT'S ACKNOWLEDGMENT

I fully understand 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 to my best knowledge and belief.

In making this application for appointment to the medical staff of this hospital, I acknowledge that I have received and read the by-laws, rules and regulations of the medical staff of this hospital, and that I am familiar with the principles and standards of the joint Commission of Accreditation of Hospitals and the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty and/or profession. I agree to be bound by the terms thereof if I am granted membership or clinical privileges, and I further agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for employment to the medical staff. I further agree to abide by such hospital and staff rules and regulations as may be from time to time enacted.

By applying for appointment to the medical staff, I hereby signify my willingness to appear for the interviews in regard to my application and authorize the hospital, its medical staff and their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others (including present and past malpractice carriers) who may have information bearing on my personal competence, character and ethical qualifications. I hereby further consent to the inspection by the hospital, its medical staff and its representatives of all records and documents, including medical records at other hospitals, that may be material to the evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release from liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby release from liability any and all individuals and organizations who provide information to the hospital or medical staff, in good faith and without malice, concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges. I hereby consent to the release of such information.

I hereby authorize and consent to the release of information by this hospital or its medical staff to other hospitals, medical associations and other interested persons on request regarding any information the hospital and the medical staff may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability this hospital and its staff for so doing.

I understand and agree that I, as an applicant for medical staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I have not requested privileges for any procedures for which I am not certified. Furthermore, I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have requested privileges.

Date

Signatures of Applicant