Professional & Allied Health Staff Membership Application

Medical Staff Office
One Hurley Plaza
Flint, MI 48503
Phone: (810) 262-9239
Fax: (810) 262-9249

INSTRUCTIONS:

To be eligible for staff membership, you must be licensed to practice medicine in the State of Michigan or you must be an appropriately licensed nurse clinician, physician assistant, clinical scientist, or other licensed or registered healthcare professional (as specified in the Professional Staff Bylaws) who has been approved to provide specific patient care in the hospital.

PLEASE COMPLETE THE ENTIRE APPLICATION. If a question is not applicable, please indicate by writing or typing "Not Applicable" or "N/A". All sections highlighted in BLUE are mandatory and not providing this information may cause a delay in the credentialing of your application. Please note that the Curriculum Vitae is not an acceptable replacement for completing a section of the application.

If you have any questions or concerns regarding completion of the application or our application process, please contact the Medical Staff Office at (810) 262-9239.

I A. PERSONAL INFORMATION

1. _____ **Name (Last, First, Middle)**
2. _____ **Degree/Professional Title**
3. _____ Other Names You May Have Used (Maiden, a.k.a., etc.)
4. **Gender:** ☐ Male ☐ Female
5. _____ **Home Address/Street**
6. _____ **City/State/Zip**
7. (_____) _____ **Home Telephone No.**
8. (_____) _____ Home Fax No.
9. _____ **E-mail Address**
10. _____ **Date of Birth (Month/Day/Year)**
11. _____ **Citizenship/Place of Birth**
12. _____ Languages fluently spoken in addition to English
13. _____ Languages written in addition to English
14. _____ **Social Security No.**
15. _____ Ethnicity (Optional)
16. If you are not a US Citizen do you have authorization to work in the US? ☐ Yes ☐ No

I B. PRACTICE AREA AND PRIMARY CLINICAL AFFILIATION REQUESTED

1. Are you applying as a:

☐ **Primary Care Physician:**

- ☐ Family Practice
- ☐ Family Practice with Deliveries
- ☐ OB/Gyn
- ☐ Internal Medicine
- ☐ Internal Medicine/Pediatrics
- ☐ Other _____
- ☐ Pediatrics
- ☐ General Practice

☐ **Specialist:**

- ☐ Specialty _____
  - ☐ Sub-Specialty _____

☐ **Allied Health Practitioner:**

- ☐ Physician Assistant
- ☐ Nurse Practitioner
- ☐ Nurse Midwife
- ☐ Nurse Anesthetist
- ☐ Psychotherapist
- ☐ Other _____
- ☐ Limited Licensed Psychologist
- ☐ Social Worker

2. Other special medical interests/areas of expertise: _____

II A. PRIMARY OFFICE PRACTICE INFORMATION:

1. _____
Group Practice Name

2. _____
Address **Suite** **City** **State** **County** **Zip**

3. (_____) _____ 4. (_____) _____ 5. _____
Telephone No. **Fax No.** Office E-mail Address

6. (_____) _____ 7. (_____) _____
Emergency On-call No. Pager No.

8. _____ 9. (_____) _____ 10. (_____) _____
Office Manager **Telephone No.** **Fax No.**

11. List physicians practicing at this location: Specialty:

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

II B. ALTERNATES - 24-HOUR COVERAGE - ADMITTING ARRANGEMENTS ☐ N/A

Please list at least two alternates on staff at Hurley Medical Center who have agreed to cover your practice when you are unavailable for call or out of town. ONLY select "N/A" if you are requesting COURTESY STATUS.

1. _____ _____ (_____) _____
Name of Practitioner **Specialty** **Telephone No.**

_____
Address **Suite** **City** **State** **Zip**

2. _____ _____ (_____) _____
Name of Practitioner **Specialty** **Telephone No.**

_____
Address **Suite** **City** **State** **Zip**

3. Do you have arrangements for 24-hour, 7-days-a-week medical coverage for your patients? ☐ Yes ☐ No
If no, please explain: _____

_____
No If no, please explain:

4. Do you currently admit and care for your hospitalized patients? ☐ Yes ☐

_____

II C. ALLIED HEALTH PRACTITIONER SUPERVISING PHYSICIANS ☐ N/A

1. _____ _____ (_____) _____
Name of Supervising Physician Specialty Telephone No.

2. _____
Address Suite City State Zip

III A. MEDICAL / PROFESSIONAL SCHOOL

List all Medical Schools/Institutions attended including undergraduate and graduate school for allied health practitioners. Enclose copies of your diplomas and certificates.

1. Medical/Professional School _____ Degree Awarded _____ Date of Graduation (mm/yy) _____

   Address _____ City _____ State _____ Zip _____

2. Medical/Professional School _____ Degree Awarded _____ Date of Graduation (mm/yy) _____

   Address _____ City _____ State _____ Zip _____

III B. POST GRADUATE TRAINING

List all training attended. Enclose copies of your certificates. Explain any 30-day or greater gap in your training on a separate sheet.

1. INTERNSHIP Program successfully completed? ☐ Yes ☐ No

Institution/Hospital _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____

Address _____ City _____ State _____ Zip _____

Program Specialty _____ Program Director _____ (_____) Telephone No. _____

2. RESIDENCY Program successfully completed? ☐ Yes ☐ No

Institution/Hospital _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____

Address _____ City _____ State _____ Zip _____

Program Specialty _____ Program Director _____ (_____) Telephone No. _____

3. FELLOWSHIP Program successfully completed? ☐ Yes ☐ No

Institution/Hospital _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____

Address _____ City _____ State _____ Zip _____

Program Specialty _____ Program Director _____ (_____) Telephone No. _____

4. OTHER _____

Program successfully completed? ☐ Yes ☐ No

Institution/Hospital _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____

Address _____ City _____ State _____ Zip _____

Program Specialty _____ Program Director _____ (_____) Telephone No. _____

5. OTHER _____

Program successfully completed? ☐ Yes ☐ No

Institution/Hospital _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____

Address _____ City _____ State _____ Zip _____

Program Specialty _____ Program Director _____ (_____) Telephone No. _____

Directions for Sections IV & V: List in chronological order (with the current affiliation first) all institutions where you have current affiliations and have had previous hospital privileges. This includes hospitals, residential treatment and rehabilitation centers, surgery centers, institutions, corporations, military assignments, or government agencies. Work history should include self-employment. If more space is needed, attach additional sheet(s). **A curriculum vitae (CV) is not sufficient as replacement for these sections.**

IV. HOSPITAL / FACILITY HISTORY

1. _____ _____ _____
CURRENT Primary Admitting Facility Dates From (mm/yy) Dates To (mm/yy)

_____
Address Suite City State Zip

_____ _____ (_____) _____ (_____) _____
Department/Specialty Staff Category Telephone No. Fax No.

2. _____ _____ _____
Admitting Facility Dates From (mm/yy) Dates To (mm/yy)

_____
Address Suite City State Zip

_____ _____ (_____) _____ (_____) _____
Department/Specialty Staff Category Telephone No. Fax No.

3. _____ _____ _____
Admitting Facility Dates From (mm/yy) Dates To (mm/yy)

_____
Address Suite City State Zip

_____ _____ (_____) _____ (_____) _____
Department/Specialty Staff Category Telephone No. Fax No.

4. _____ _____ _____
Admitting Facility Dates From (mm/yy) Dates To (mm/yy)

_____
Address Suite City State Zip

_____ _____ (_____) _____ (_____) _____
Department/Specialty Staff Category Telephone No. Fax No.

5. _____ _____ _____
Admitting Facility Dates From (mm/yy) Dates To (mm/yy)

_____
Address Suite City State Zip

_____ _____ (_____) _____ (_____) _____
Department/Specialty Staff Category Telephone No. Fax No.

V. WORK HISTORY [Add additional sheets if more space required.]

Chronologically list all work history activities since completion of postgraduate training. Explain any gaps of more than thirty days.

1. _____ _____ _____ _____
Current Practice/Employer Contact Name Dates From (mm/yy) Dates To (mm/yy)

_____
Address Suite City State Zip

_____ _____ (_____) _____ (_____) _____
Position Staff Category Telephone No. Fax No.

2. _____ _____ _____ _____
Previous Practice/Employer Contact Name Dates From (mm/yy) Dates To (mm/yy)

_____
Address Suite City State Zip

_____ _____ (_____) _____ (_____) _____
Position Staff Category Telephone No. Fax No.

3. _____ _____ _____ _____
Previous Practice/Employer Contact Name Dates From (mm/yy) Dates To (mm/yy)

_____
Address Suite City State Zip

_____ _____ (_____) _____ (_____) _____
Position Staff Category Telephone No. Fax No.

VI. UNACCOUNTED FOR TIME GAPS

Please use the space below to explain any intervals of time not accounted for previously in the application, beginning with your professional degree and ending with your current employer/affiliation. Please attach an additional sheet with a detailed explanation.

Suspended from Practice _____ From _____ To _____

Loss of License _____ From _____ To _____

Served in Military _____ From _____ To _____

Personal Leave _____ From _____ To _____

Personal Leave _____ From _____ To _____

Other (Please describe) _____ From _____ To _____

Other (Please describe) _____ From _____ To _____

Other (Please describe) _____ From _____ To _____

Other (Please describe) _____ From _____ To _____

VII. MEDICAL / PROFESSIONAL LICENSURE

1. _____ _____ _____
   Michigan State Medical / Professional License No. | Date First Issued | Expiration Date

2. _____ _____
   Michigan State Controlled Substance No. | Expiration Date

3. _____ _____
   Drug Enforcement Administration Certification No. (DEA) | Expiration Date

4. ALL OTHER STATE MEDICAL/PROFESSIONAL LICENSES:

   State: _____ License No.: _____ Expiration Date: _____

   State: _____ License No.: _____ Expiration Date: _____

   State: _____ License No.: _____ Expiration Date: _____

   State: _____ License No.: _____ Expiration Date: _____

   State: _____ License No.: _____ Expiration Date: _____

5. _____ 6. _____
   NPI (National Provider Identifier) | ECFMG No.

VIII. BOARD CERTIFICATIONS

Name of Board/Certifying Entity	Certificate No.	Date Certified / Re-certified	Expiration Date	Specialty
1.				
2.				
3.				

Have you applied for board certification other than those indicated above? ☐ Yes ☐ No

If yes, list board(s) and date(s): _____

If not certified, do you intend to apply? Yes ☐ Specify timeframe: _____

No ☐ Specify reason: _____

Have you ever taken and not passed a medical board examination? ☐ Yes ☐ No If yes, will you re-take? ☐ Yes ☐ No

IX. REFERENCES

List four professional references, NOTE: References must be from individuals who are directly familiar with your work, either clinical observation or close working relations, not including relatives, and not more than one current partner or associate.

Physicians: Please list four professional references (physicians), who will be contacted by the Medical Staff Office to supply recommendations relative to your appointment.

- One must be a member of the medical staff of Hurley Medical Center
- One must be the Chief of Service at the hospital where you received your training. If in practice for more than three years, this reference must be the Chief of Service at your major hospital affiliation.
- The others must be peers, preferably from your specialty area, who will be able to attest to your current health status and competency to perform the privileges you are requesting.

Allied Health Staff: Please supply the names of four physicians/professionals who will be contacted by the Medical Staff Office to supply recommendations relative to your appointment.

- One must be the Chief of Service at the hospital where you received your training. If in practice for more than three years, this reference must be the Chief of Service at your major hospital affiliation.
- The others must be peers, preferably from your specialty area, who will be able to attest to your current health status and competency to perform the privileges you are requesting.

1. _____ _____ (_____) _____
   Name Title/Relationship Telephone No.
   _____ (_____) _____
   Address City State Zip Fax No
   Email Address: _____

2. _____ _____ (_____) _____
   Name Title/Relationship Telephone No.
   _____ (_____) _____
   Address City State Zip Fax No
   Email Address: _____

3. _____ _____ (_____) _____
   Name Title/Relationship Telephone No.
   _____ (_____) _____
   Address City State Zip Fax No
   Email Address: _____

4. _____ _____ (_____) _____
   Name Title/Relationship Telephone No.
   _____ (_____) _____
   Address City State Zip Fax No
   Email Address: _____

X. PROFESSIONAL LIABILITY CARRIER INFORMATION

Please list all of your professional liability carriers for the **past five years**:

Does your current professional liability insurance cover you in all of your practice locations? ☐ Yes ☐ No

1. _____ _____
Current Insurance Carrier Policy No.

_____ (_____) _____
Address City State Zip Telephone No.

_____ _____ _____
Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

_____ _____ _____
Initial Date of Coverage Retroactive Date of Coverage Expiration Date

2. _____ _____
Current Insurance Carrier Policy No.

_____ (_____) _____
Address City State Zip Telephone No.

_____ _____ _____
Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

_____ _____ _____
Initial Date of Coverage Retroactive Date of Coverage Expiration Date

3. _____ _____
Current Insurance Carrier Policy No.

_____ (_____) _____
Address City State Zip Telephone No.

_____ _____ _____
Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

_____ _____ _____
Initial Date of Coverage Retroactive Date of Coverage Expiration Date

4. _____ _____
Current Insurance Carrier Policy No.

_____ (_____) _____
Address City State Zip Telephone No.

_____ _____ _____
Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

_____ _____ _____
Initial Date of Coverage Retroactive Date of Coverage Expiration Date

5. _____ _____
Current Insurance Carrier Policy No.

_____ (_____) _____
Address City State Zip Telephone No.

_____ _____ _____
Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

_____ _____ _____
Initial Date of Coverage Retroactive Date of Coverage Expiration Date

XI. CLAIM / LAWSUIT HISTORY - 5 YR. HISTORY

If you answer "YES" to any of the following questions, please provide details per the attached claims information sheet. Please explain any surcharge to your professional liability coverage on a separate sheet.	**YES**	**NO**
Have you ever been a defendant in a malpractice suit?		
Have any judgments been made against you or settlements been agreed to in any professional liability cases?		
Are there any professional liability lawsuits pending against you at the present time?		
Has your professional liability insurance ever been terminated or restricted or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?		

XII. HEALTH STATUS

If the answer to any question is "YES", reference the question on a separate sheet. Please provide a full explanation and attach.	**YES**	**NO**
Are you currently using any chemical substance(s), which in any way may impair or limit your ability to practice medicine with reasonable skill and safety?		
Are you currently engaged in the illegal use of controlled substances?		
Do you have a mental or physical condition, which in any way may impair or limit your ability to practice medicine with reasonable skill and safety with or without reasonable accommodation?		

XIII. PROFESSIONAL PRACTICE

Have any of the following been or are currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, reviewed, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other state, territory or country? If "YES", provide full explanation and attach.	**YES**	**NO**
Medical or professional license		
DEA Registration or Controlled Substance license		
Hospital medical staff membership		
Clinical privileges or other rights on any hospital medical staff		
Employment by any hospital, institution or the military		
Professional society membership		
Participation in any private, federal, or state health insurance program (i.e. Medicare, CHAMPUS, Medicaid)		
Participation in an HMO, PPO, or any other managed care organization		
Board Certification		

XIV. OTHER DISCLOSURES

At any time have you ever been:	**YES**	**NO**
Convicted of any criminal offense in any jurisdiction		
Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of trial, or an accelerated rehabilitation disposition of felony charges in any state, territory or country		
Have you ever, at any time, or are you currently:	**YES**	**NO**
Under audit by a Health Care Agency (i.e. Medicare, Medicaid, MDCH, or any insurance)		
Under indictment for any crime		
The subject of an investigation by any private, federal or state health insurance program or state, territory or country licensing board		
The subject of any adverse action reports to a state or federal agency		
Sanctioned by a government program or agency for any reason		
Have you ever, at any time, either voluntarily or involuntarily:	**YES**	**NO**
Withdrawn your application for medical staff membership at any facility		
Withdrawn your request for any clinical privileges at any facility		

XVII. ATTESTATION STATEMENT

If accepted for membership on the Professional Staff of Hurley Medical Center, I agree/pledge to provide continuous care to my patients in the hospital, within the generally recognized professional standards of quality, efficiency and appropriateness; abide by the Bylaws, Policies, Policies and Procedures, and Rules & Regulations imposed by the Professional Staff or governing body of Hurley Medical Center, as well as Hurley Medical Center Standard Practices/Policies and Procedures, Rules & Regulations; carry out responsibilities for which I am appointed/elected to my department, committee, or the hospital; complete my medical records in a timely manner for all patients admitted to the hospital or for whom I provide care; and abide by the ethical principles of my profession.

I understand that I may voluntarily agree to participate in the supervision/ education of residents/fellows at the request of the director of a particular residency/fellowship program. I understand that all of the patient responsibility belongs to the attending physician who is participating with a member of the house staff in the patient care. I also understand that if I elect not to participate in the supervision/ education of residents/fellows, I will not be in jeopardy with respect to my staff privileges.

KNOWING THAT PROVIDING FALSE INFORMATION MAY RESULT IN THE DENIAL OF MY APPOINTMENT, I DECLARE THAT I HAVE EXAMINED THIS APPLICATION AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION I HAVE PROVIDED IS TRUE, CORRECT, AND COMPLETE.

Signature: _____

Date: _____

RELEASE FROM LIABILITY

TO WHOM IT MAY CONCERN:

I, the undersigned, an applicant for staff membership at Hurley Medical Center, Flint, Michigan, do hereby authorize Hurley Medical Center to consult with members of medical staffs of other hospitals with which I have been associated and with others who may have information bearing on my competence, character, and ethical qualifications. I hereby authorize and consent to such other health care entities providing such information in good faith to Hurley Medical Center.

I further consent to the inspection by Hurley Medical Center of all records and documents that may be material to an evaluation of my professional qualifications and competence to carry out the privileges I have requested, as well as of my moral and ethical qualifications for staff membership.

I do hereby release from any and all liability all representatives of Hurley Medical Center, its medical staff and other health care entities providing information in good faith, for their acts performed in response to a request by Hurley Medical Center representatives relating to my ability, professional ethics, character, physical and mental health, emotional stability and other qualifications for staff appointment and clinical privileges.

I also authorize and consent to Hurley Medical Center providing other hospitals, medical associations, licensing boards and other organizations concerned with provider performance and the quality, appropriateness and efficiency of patient care services rendered, with any information relevant to such matters that Hurley Medical Center may have concerning me. I hereby release from any and all liability Hurley Medical Center for providing such other health care entities with such information.

I understand that Hurley Medical Center will be releasing and requesting information in accordance with the Health Care Quality Improvement Act of 1986 and specifically consent to such action and also hereby release from any and all liability Hurley Medical Center and its representatives for such requests and releases of information. Note: A photostatic copy of this release shall be considered as valid and effective as the original.

Applicant's Name (Printed)	Applicant's Signature	Date
Witness' Name (Printed)	Witness' Signature	Date

SUPPLEMENTAL CLAIMS INFORMATION FORM **N/A ☐ If no claims.**

(PLEASE COMPLETE A SEPARATE FORM FOR EACH CLAIM)

Claim Number or Patient Initials: _____ Age: _____ Gender: _____

Incident Is: ☐ Pending Closed Date: _____

☐ Dismissed Date _____

☐ Settlement Date _____ $ _____

☐ Judgment Date _____ $ _____

You Are: ☐ Solo Defendant

☐ Co-Defendant With _____

☐ Other _____

Were the Settlement Terms Confidential? ☐ Yes ☐ No

Settlement/Judgment Details: _____

Amount Paid on Your Behalf: _____

Date of Incident: _____ Date Suit Filed: _____

Court: _____ Case No.: _____

Name and Address of Insurance Carrier at Time of Incident: _____

_____

Name of Additional Defendant(s): _____

_____

Explain in Detail the Plaintiff's Allegations: _____

_____

_____

Explain in Detail your Defenses to These Allegations: _____

_____

_____

Patient's Condition Post-Incident: _____

_____

_____

Whom may we consult for further legal information about the suit: _____

_____

_____

_____ _____

Signature of Applicant Date

_____

Print Name