HURLEY MEDICAL CENTER

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. (_____) _____ **Cell Phone 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 (As Appears on SS4 or W-9 Form)

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: _____

_____

4. Do you currently admit and care for your hospitalized patients? ☐ Yes ☐ No If no, please explain:

_____

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.