



**OTHER STATE MEDICAL LICENSES – PAST AND PRESENT**

State Registration/Number                      Date    State Registration/Number                      Date

**PREMEDICAL EDUCATION**

College/University    Degrees/Honors

Address    Date of Graduation

**MEDICAL EDUCATION**

College/University    Degrees/Honors

Address    Date of Graduation

**INTERNSHIP**

Hospital    Dates Attended

Address    Full Name of Program Director

Type    Kind (Medical, Surgical, etc.)

**RESIDENCY PROGRAMS**

Hospital    Dates Attended

Address    Description

Hospital    Dates Attended

Address

**TRAINING, FELLOWSHIPS, PRECEPTORSHIPS, POSTGRADUATE EDUCATION**

List in chronological order. Give complete school or hospital name and address, including ZIP codes, beginning and ending dates, and name of the immediate supervisor.

School or Hospital (1)    Address

Dates    Superior

Applicant Initials \_\_\_\_\_ Date \_\_\_\_\_

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School or Hospital (2)

Address

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Dates

Superior

### HOSPITAL AND UNIVERSITY AFFILIATIONS

List all present and past affiliations in chronological order. Indicate "Staff Status" as : Active/Courtesy, etc. or Academic Title. Use additional sheet if necessary.

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Name of Institution (1)

Address

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Dates Affiliated

Staff Status

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Department

Dept. Chief/Chair (Full Name)

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Name of Institution (2)

Address

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Dates Affiliated

Staff Status

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Department

Dept. Chief/Chair (Full Name)

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Name of Institution (3)

Address

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Dates Affiliated

Staff Status

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Department

Dept. Chief/Chair (Full Name)

### PREVIOUS MEDICAL PRACTICE

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Type

Location (Address/Group Name)

Dates Practicing

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Type

Location (Address/Group Name)

Dates Practicing

### CERTIFICATION

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Certified by American Board of (Specialty)

Certification #

Date of Certification

Expires

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If Not Certified, Give Present Status

Date

Date of Exam

### PROFESSIONAL PEER REFERENCES

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Name (1)

Professional Relationship

Address

Applicant Initials \_\_\_\_\_ Date \_\_\_\_\_

Name (2) Professional Relationship Address

Name (3) Professional Relationship Address

PROFESSIONAL LIABILITY

Insurance Carrier Amount of Coverage

Policy # Expiration Date

Have any professional liability lawsuits been filed against you during the past ten years (including those closed)?.....  Yes  No

Are there any now that are still pending?.....  Yes  No

Has any judgement or settlement ever been made against you in any professional liability cases?.....  Yes  No

Have you ever been denied professional insurance, or has your policy ever been cancelled?.....  Yes  No

If yes to any of the above, please explain on a separate sheet.

PROFESSIONAL SANCTIONS

Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license even been withdrawn? .....  Yes  No

Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers? .....  Yes  No

Have you lost any board certification(s), and/or failed to rectify? .....  Yes  No

Have you been examined by a Capital Certifying Board but failed to pass? .....  Yes  No

Has any information pertaining to you, including malpractice judgments or disciplinary action, ever been reported to the National Practitioner Data Bank and/or any other practitioner data bank? .....  Yes  No

Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily, or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration? .....  Yes  No

Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed?...  Yes  No

Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? .....  Yes  No

Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license? .....  Yes  No

Applicant Initials \_\_\_\_\_ Date \_\_\_\_\_

Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs? .....  Yes  No

Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third-party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues? .....  Yes  No

Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g., hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO? .....  Yes  No

Have you withdrawn an application or any portion or an application for appointment or reappointment for clinical privileges or staff appointment or for license or membership in an IPA, PHO, professional group or society, health care entity, or health care plan prior to a final decision to avoid a professional review or an adverse decision? .....  Yes  No

Have you ever been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country? .....  Yes  No

Have you been the subject of a civil or criminal or administrative action or been notified in writing that you are being investigated as the possible subject of a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse? .....  Yes  No

*If yes to any of the above, please explain on separate sheet.*

**HEALTH STATUS**

Do you have a medical condition, physical defect or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety? .....  Yes  No

Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation? .....  Yes  No

*If yes to any of the above, please explain on a separate sheet.*

**CHEMICAL SUBSTANCES OR ALCOHOL ABUSE**

Are you currently engaged in illegal use of any legal or illegal substances? .....  Yes  No

Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? .....  Yes  No

*If yes to any of the above, please explain on a separate sheet.*

By applying for clinical privileges, I hereby signify my willingness to appear for interviews in regard to my application, and I authorize the organization, its medical staff, and their representatives to consult with members of management and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to inspection by the "Organization," its medical staff, and its representatives of all records and documents, including medical and credential records at other hospitals, which may be material to an evaluation of my qualifications for staff membership. I hereby release from liability all representatives of the "Organization" and its medical staff, in their individual and collective capacities, for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the "Organization" or to members of its 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 information by other hospitals, other medical associations, and other authorized persons, on request, regarding any information the "Organization" 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 and hold harmless the "Organization" and any other third party for so doing. I understand and agree that I, as an applicant for clinical privileges, have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics, and other qualifications and for the resolutions of any doubts about such qualifications.

By accepting appointment and/or reappointment to the medical staff at Peninsula Procedure Center (the "Organization"), I hereby acknowledge and represent that I have read and am familiar with the bylaws, rules, and regulations of the "Organization," as well as the principles, standards, and ethics of the national, state and local associations and state law and regulations that apply to and govern my specialty and/or profession, which are the "Governing Standards". I further agree to abide by such further Governing Standards as may be enacted from time to time.

In addition, I agree to notify the "Organization" of any circumstances that would change my status in licensure, DEA, Medicare participation, liability insurance coverage or Board certification status or hospital privileges. I understand and agree that any significant misstatements in or omissions from this application shall constitute cause for denial of appointment or cause for summary dismissal from the medical staff with no right of appeal. All information submitted by me in this application is true to the best of my knowledge and belief.

I further authorize a photocopy or facsimile of the requests, authorizations and release to the application to serve as the original.

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Signature of Applicant

Date

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Print Name

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Medical Director

Date

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Governing Body

Date

Applicant Initials \_\_\_\_\_ Date \_\_\_\_\_