
APPLICATION

for

***Medical Staff Appointment
Student***

INSTRUCTIONS

1. *Please type or print legibly.*
2. *All information requested must be FULLY and TRUTHFULLY provided. **If more space is needed than provided on the application form, attach additional sheets.** Reference the question being answered.*
3. *All questions must be answered. If not applicable, write "N/A" in the answer block.*

Please Remember to Enclose the Following:

1. *One recent passport size photograph of yourself.*
2. *Copy of School Diploma.*
3. *Copy of Current Curriculum Vitae.*
4. *Copy of Current Georgia License(s) (if applicable).*
5. *Copy of Current Certificate of Insurance-directly from broker.*

I. MEMBERSHIP AND PRIVILEGES

Are you requesting membership on the House Medical Staff of West Georgia Medical Center as a Medical Student?
Yes _____ No _____

Indicate who on the current Medical Staff you will be working with and what your responsibilities will include for this Medical Staff Member, including any clinical privileges you are requesting as this time: _____

II. IDENTIFYING INFORMATION

Name: _____
 Last First Initial (Maiden)

Any Other Names Used _____ Reason For Change _____

Name of Spouse: _____

Social Security Number: _____ Sex: _____

Birthdate: _____ Birthplace: _____

Country of Citizenship: _____
(If Not USA, Provide Status of Visa, Type of Visa)

Home Address:¹ _____
 Street City

State Zip Home Phone

Primary Office Address:² _____
 Street City

State Zip Telephone: _____ Fax: _____

Preferred mailing address

Answering Service #: _____ Beeper #: _____

Car Phone #: _____

¹ If you currently do not live in the **immediate area**, do you plan to relocate? [] Yes [] No

² Please provide a separate sheet listing all current offices and addresses, telephone and telefax numbers.

In case of Emergency, Notify _____
Name

Telephone Relation

III. EDUCATION

A. Undergraduate

Institution from which degree was obtained: _____

Address: _____

Degree: _____ Dates Attended: _____ Date of Graduation: _____
(provide months and years)

B. Medical/Graduate Program

Institution from which degree was obtained: _____

Address: _____

Name of Contact Person: _____

Degree: _____ Dates Attended: _____ Date of Graduation: _____
(provide months and years)

IV. MILITARY/PUBLIC HEALTH SERVICE

Branch: _____

Rank at Discharge: _____ Dates of Service: _____
(provide months and years)

Address at time of Service: _____

Honorable Discharge: [] Yes [] No; If not, Give Details: _____

V. MEMBERSHIP IN PROFESSIONAL SOCIETIES

Please list all professional organizations or societies (local, state and national) in which you have membership:

VI. HOSPITAL AFFILIATIONS

Previous Affiliation with this hospital: [] Yes [] No; If yes, dates: _____

All Current and Previous Hospital Affiliations: Starting with the most current (including appointments).

Hospital: _____ Staff Category: _____ Date(s): _____
(month/year)

Address: _____ Type of Privileges: _____
Medical Staff Member associated with: _____

Hospital: _____ Staff Category: _____ Date(s): _____
(month/year)

Address: _____ Type of Privileges: _____
Medical Staff Member associated with: _____

If needed, provide any additional affiliations on a separate sheet.

VII. PROFESSIONAL REFERENCES

Provide the name of one professional reference: Program Director, Dean or other authorized medical school faculty representative.

Name: _____ Degree: _____ Telephone: _____

Address: _____

VIII. PROFESSIONAL LIABILITY INSURANCE COVERAGE AND HISTORY

Insurance Carrier: _____ Limits of Coverage: _____

Address: _____

Policy Number: _____

Have any payments been made on your behalf in connection with any judgments or settlements against you arising out of any professional liability claims? [] Yes [] No

Are there any professional liability claims, suits, or arbitration proceedings currently pending against you? [] Yes [] No

If you answered yes to either of the preceding questions, please explain in detail on additional sheets.

Provide, directly from insurance broker or company, a copy of your certificate of coverage, including name of local agent, address, policy number, coverage limits, inception date, expiration date, type of policy (claims made, occurrence, other) and exclusions, if any.

IX. HEALTH STATUS:

Yes No *Are you able to perform all the procedures for which you have requested privileges, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients? (If you will require reasonable accommodation, please use a separate sheet to describe the accommodation(s) which will enable you to perform the privileges you have requested).*

Yes No *Are you able to safely perform the clinical privileges for which you are applying, or essential duties of membership, with or without a reasonable accommodation?*

If any of the following questions are answered in the affirmative, please provide full explanation on separate sheet.

Yes No *Do you currently use alcohol in a manner that is likely to affect your ability to perform your professional or medical staff duties?*

Yes No *Do you currently use prescription or non-prescription drugs in any manner that is likely to affect your ability to perform your professional or medical staff duties?*

Yes No *Do you currently use illegal drugs, or have you used illegal drugs in the past without rehabilitation or treatment?*

Most recent physical examination: Date: _____ Performed By: _____

Regardless of how these questions are answered, the application will be processed in the usual manner. If you have answered any of these questions affirmatively and are found to be professionally qualified for medical staff appointment and the clinical privileges requested, you will be given an opportunity to meet with the Credentials Committee to determine what accommodations, if any, are necessary or feasible to allow you to practice safely.

X. GENERAL

Yes No 1. *Have you ever been convicted of a crime (other than minor traffic offenses)?*

Yes No 2. *Have you ever been reprimanded, suspended, or denied membership or renewal in, or been subject to disciplinary proceedings in any professional or medical organization?*

Yes No 3. *Have your privileges at any hospital or other health care facility ever been diminished, placed on probation, subjected to non-routine monitoring, not renewed, deferred, suspended or revoked?*

Yes No 4. *Have you voluntarily or involuntarily resigned membership or privileges from any hospital or other health care facility staff?*

Yes No 5. *Has your application for clinical privileges or staff membership or advancement at any hospital or health care facility ever been denied in whole or in part - or is any such action pending?*

- Yes No 6. *Have you ever resigned from a hospital or other health care facility staff to avoid disciplinary action, investigation or while under investigation or is such investigation pending?*
- Yes No 7. *Have you voluntarily or involuntarily relinquished or reduced your privileges at any hospital or other health care facility or dropped any hospital or other health care facility from your practice?*
- Yes No 8. *Have you ever resigned or been asked to resign from a professional society?*
- Yes No 9. *Do your professional activities require that your primary responsibility is to another hospital, medical school, government agency, or other entity?*
- Yes No 10. *Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (for example, Medicare or Medicaid)?*
- Yes No 11. *Has any professional review organization under contract with Medicare ever made an adverse quality determination concerning your treatment rendered to any patient?*

If you have answered "Yes" to any of Questions 1 through 11, please fully explain the circumstances on a separate sheet including the following details, as applicable: dates, identity of parties, nature of proceedings, status and outcome.

Statement of Applicant

PLEASE READ CAREFULLY BEFORE SIGNING

I understand that the medical staff of this hospital is responsible for the evaluation of my professional competence and qualifications, and has the obligation to inquire into my competence, professional training, experience, professional conduct and judgment, and other factors, and to make appropriate recommendations to the governing body of this hospital.

All information submitted by me in this application is true to the best of my knowledge and belief. I fully understand that any misstatement in, or omissions from, this application may constitute cause for denial of appointment or reappointment, or cause for summary dismissal from the allied health professional staff at the time of discovery.

By applying for appointment or reappointment to the allied health professional staff, I acknowledge that I have received a copy of the medical staff bylaws and rules and regulations. I acknowledge that I have the responsibility to read the medical staff bylaws and rules and regulations. I agree to be bound by the terms of such documents and all other applicable policies of the hospital or its medical staff as may from time to time be in effect if I am granted allied health professional staff membership or clinical privileges. I agree to conduct my practice in accordance with applicable law and ethical principles of my profession and to provide for continuous care for my patients.

I understand and acknowledge that the Hospital must report to the National Practitioner Data Bank (NPDB), through the State Medical Board, a) any professional review action that adversely affects my clinical privileges for a period longer than 30 days, or b) acceptance of the surrender of clinical privileges or any restriction of such privileges by me while under investigation by the Hospital for possible incompetence or improper professional conduct or in return for not conducting such an investigation.

I agree that it is my duty and ethical responsibility as an individual and as an applicant or member of the allied health professional staff of this hospital to cooperate with and assist the medical staff in evaluating not only my professional qualifications, but also those of my colleagues. I hereby signify my willingness to appear before medical staff and hospital officers and committees for interviews or inquiries at reasonable times and places. I consent to the communication of information and documents between this Hospital and its medical staff, and other Hospital medical staffs, medical schools, training programs, medical societies, professional associations, professional liability insurance companies, and licensing authorities in jurisdictions in which I have trained, resided, practiced, or applied for professional license, privileges or membership, for the evaluation of my qualifications, professional training, experience, character, conduct, ethics and judgment. I hereby further consent to the inspection by the Hospital, the medical staff(s) and their representatives of all documents that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for allied health professional staff membership. In this regard, the utmost care shall be taken to safeguard my privacy and the privacy of patients and confidentiality of patient records. I hereby release from any liability any and all individuals and organizations who provide information to the Hospital or its medical staff in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I agree that it is my duty and ethical responsibility as an individual and as an applicant or a member of the Allied Health Professional Staff of this Hospital to cooperate with and assist the Medical Staff in obtaining information pertinent to the consideration of my professional qualifications and, therefore, I hereby authorize and consent to the observation by a member of the Hospital's Medical Staff of all procedures which I may perform as an Allied Health Professional Staff member. Further, I hereby release the Hospital, its employees, officers, and directors, and all Medical Staff members who may observe my performance of such procedures from any and all claims, actions, causes of action, accounts, or liabilities in connection with or arising out of compliance by any of the foregoing with such observation requirements.

I hereby consent and authorize all hospitals or health care facilities where I currently have staff privileges, have had privileges in the past or have made application for privileges, to report, release and exchange information among themselves and to any government agency and any state licensure body, related to the following: (1) any payments made for my benefit under a policy of insurance, self-insurance, or otherwise in settlement or partial settlement of, or in satisfaction of a judgment in, a medical malpractice action or claim; (2) any action or formal disciplinary procedure that adversely affects my clinical privileges, including the reduction, restriction, suspension, revocation, denial or failure to renew such privileges for reasons relating to my professional competence or conduct; (3) any surrender of my clinical privileges accepted by a healthcare entity relating to possible incompetence or improper professional conduct or any surrender of clinical privileges accepted by a healthcare entity in return for not conducting such investigation or proceeding; (4) any professional review action of a professional society which adversely affects my membership in the society; and (5) any surrender of my license or censure, reprimand, limitation, revocation, involuntary surrender, restriction or probation of applicant by the Board of Medical Examiners of any state for reasons relating to my professional competence or professional conduct.

I hereby further release from liability this Hospital, its representatives, and its medical staff for their acts performed and statements made in good faith and without malice in evaluating my professional competence, ethics, character and other qualifications for allied health professional staff appointment and clinical privileges in connection with this application.

I understand and agree that this consent is irrevocable for so long as I am an applicant for or have allied health professional staff privileges at the Hospital.

I understand and agree that I, as an applicant for allied health professional staff membership or privileges, 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, and for updating my application with all relevant information not contained in my original application.

I understand and agree that no action will be taken on this application until it is complete and all outstanding questions with respect to the application have been resolved.

A photocopy of this waiver shall be as effective as the original when so presented.

Date: _____

Name: _____

Signature _____