MEDSTAR UNION MEMORIAL HOSPITAL
APPLICATION INSTRUCTIONS FOR REAPPOINTMENT

Prior to completing the following application, please read and observe the following:

You will be contacted by the Medical Staff Office when it is time for your reappointment.

GENERAL INSTRUCTIONS:

- You will be asked to electronically sign certain portions of the following MedStar Union Memorial Hospital (MUMH) Reappointment Application. By electronically signing your name, you are certifying that the information you are providing is true and correct to the best of your knowledge, and that such information can be used for the processing of your MUMH Reappointment Application. If you are no longer interested in maintaining your privileges at MedStar Union Memorial Hospital, please forward a letter to the Medical Staff Office including an effective date of your resignation.
- Please type or print legibly your responses. Any changes to your responses must be lined through and initialed/dated. Please be advised that use of any form of correctional fluid or tape is ***not*** acceptable.
- Delineation of privilege forms are separate from the application and also located on the website. Active physicians must complete delineation(s), as applicable, and submit with the application. For your convenience, you may type your name in applicable areas and single click the upper right hand corner of the ***requested column*** for privileges you are requesting prior to printing. For manual completion, please print/sign your name in applicable areas and individually check (✓) the ***requested column*** for privileges you are requesting. Please be advised lines drawn down the form(s) are unacceptable.
- The Moderate Sedation application included in this document must be completed and returned with the application (even if you are not requesting). Only the Department of Anesthesia is exempt from completion.
- Medical staff dues made payable to the **"Visiting Staff Fund"** as applicable, ***must*** accompany your application unless you are a 30+ years of service physician. Please be advised 30+ years of service physicians ***are not*** exempt from the application deadline. The Medical Staff Office will notify 30+ year physicians.
- Documents to return to the Medical Staff Office:
    1. Completed/signed application.
    2. Delineation of privilege form(s), Moderate Sedation Application (include current supporting documentation or check the box which indicates "not requesting" as applicable).
    3. CME Logs.
    4. Medical staff dues, as applicable, and any other supporting credentialing documents.
- If more space is needed to answer a question completely, please use a separate page where necessary.
- Please sign and date the Application Form for Reappointment in all applicable areas.
- You will be notified when to submit claim history information. PLEASE DO NOT SUBMIT CLAIM HISTORIES SEARCHED PRIOR TO JUNE 1ST OF THE RENEWAL (CURRENT) YEAR AS THEY WILL NOT BE ACCEPTED.

A current copy of the following documents (if changed/or renewed from the date of your last (re)appointment) must be submitted with your Application for Reappointment:

- ACLS/BLS Healthcare Provider Certification
- Board Certification
- Curriculum Vitae
- Fluoroscopy Certification
- MD CDS License
- MD Federal DEA License

Case Logs during the past two years must be submitted if requesting the following privilege (see delineation for requirements:

- Cardiovascular Disease:
    1. Cardiac Catherization Lab - Interventional Procedures
    2. Cardiac Electrophysiology Lab - Laser Lead Extraction
- Endovascular Surgery

MEDSTAR UNION MEMORIAL HOSPITAL
APPLICATION FORM FOR REAPPOINTMENT

REAPPLICATION FOR MEDICAL STAFF APPOINTMENT/MEMBERSHIP - PART I

**PLEASE COMPLETE THE INFORMATION ON THE FOLLOWING PAGES THOROUGHLY. IF A REQUIRED ITEM IS NOT APPLICABLE TO YOU, PLEASE WRITE N/A ON THE APPROPRIATE LINE.

I. IDENTIFYING INFORMATION *Please provide the practitioners full legal name.*

Last Name (incl. suffix; Jr., Sr., III): | First: | Middle:

Department/Specialty:

Primary Office/Mailing Address:

Primary Office Number: | Primary Office Fax Number:

Can your Primary Office number be used for 24 hr. coverage? **Yes** ☐ **No** ☐
If not, what number should be used for 24 hr. coverage?

Email Address: _____

Home Address:

Home Telephone Number: | Cell Number:

II. BOARD CERTIFICATION/RECERTIFICATION STATUS ☐ **No Changes**

(If your board certification status has changed in the past two years, please send a copy of your certification letter.)

Certified by American Board of: _____

Recertified by American Board of:_____

III. LICENSURE

(List all countries/states other than Maryland in which you have held licensure in the past two (2) years)

State/Country	License No.	Expiration Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. CURRENT/NEW AFFILIATIONS/EMPLOYMENT

(*Please list the **name and complete address** of hospital(s) where you have been affiliated in the last two years. Use a separate page if additional space is required.*)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Name:_____

V. CONTINUING EDUCATION

(Please list all continuing education activities that are related to your specialty in accordance with your current MD State License. If more space is needed please attach documentation. If none, please explain.**)**

DATE	Name of Conference - Seminar - Topic	No. of Credits
	Total Credits	

Name:_____

REAPPLICATION FOR MEDICAL STAFF APPOINTMENT/CLINICAL PRIVILEGES – PART II

CURRENT STATUS AND REAPPOINTMENT REQUEST

1. While seeking reappointment to MedStar Union Memorial Hospital, are you interested in requesting appointment to other MedStar Health affiliated hospitals medical staff? If yes, identify hospital(s). ☐ Yes ☐ No

   ☐ MedStar Franklin Square Medical Center
   ☐ MedStar Good Samaritan Hospital
   ☐ MedStar Harbor Hospital
   ☐ MedStar Union Memorial Hospital

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2. If already appointed to more than one MedStar Health affiliated hospital's medical staff, are you requesting a change in primary or secondary hospital affiliation designation? If yes, identify which hospital should be designated as the primary hospital (P) and which hospitals should be designated as secondary hospital (s). ☐ Yes ☐ No

   ☐ MedStar Franklin Square Medical Center
   ☐ MedStar Good Samaritan Hospital
   ☐ MedStar Harbor Hospital
   ☐ MedStar Union Memorial Hospital

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3. Are you requesting a change in your appointment category(ies)?
   If yes, state below the category(ies) to which you would like to be appointed next to the Hospital listed and the reason for the change. Please refer to the medical staff bylaws of each hospital for the specific definitions of the staff categories. Copies of the medical staff bylaws may be obtained by contacting the appropriate medical staff office. ☐ Yes ☐ No

   ☐ MedStar Franklin Square Medical Center _____
   _____

   ☐ MedStar Good Samaritan Hospital _____
   _____

   ☐ MedStar Harbor Hospital _____
   _____

   ☐ MedStar Union Memorial Hospital _____
   _____
   _____

4. Will you be, or are you presently, a member of a group or practice partnership: ☐ Yes ☐ No

   If yes, please state name of group or practice partnership: _____

5. Please attach a list of a <u>new</u> teaching or research experience or membership, awards, or other recognitions conferred or granted by any professional health care societies, institutions or organizations within the past two (2) years. ☐ See Attached ☐ N/A

6. Please attach a list of all publications within the past two (2) years.
   ☐ See Attached ☐ N/A

Name:_____

HEALTH STATUS

7. Please check **only** the appropriate box:

☐ I certify that, to the best of my knowledge, I am in good health and have no physical or mental limitations that would adversely affect my ability, skill, attitude, or judgment to practice within the scope of privileges for which I currently hold.

☐ I have one or more physical or mental limitations to my health but, to the best of my knowledge, I believe that my ability to proficiently perform the clinical privileges and responsibilities I currently hold will not be impaired. A full statement of explanation regarding my limitation(s), including the name and address of my personal physician, is attached.

****Please provide date of last physical exam _____**

DISCIPLINARY ACTIONS

8. If any of these questions is answered in the affirmative, please provide a full explanation on a separate sheet.

In the past two (2) years, has any claim, complaint or action been initiated (whether or not the outcome was favorable) or has there been any continuing ongoing investigation, review or follow up in progress to deny, revoke, suspend, change, reduce, limit, place on probation, not renew, or voluntarily or involuntarily relinquish any of the following?

Administrative appointment?	☐ Yes ☐ No
Medical license in any state?	☐ Yes ☐ No
Other professional registration/license?	☐ Yes ☐ No
DEA registration or state drug license?	☐ Yes ☐ No
Academic appointment?	☐ Yes ☐ No
Appointment on any medical staff of any health care facility?	☐ Yes ☐ No
Clinical privileges from any medical staff or any health care facility?	☐ Yes ☐ No
Clinical privileges from any medical staff or any health care facility while under a peer review investigation?	☐ Yes ☐ No
Other institutional affiliation, employment or independent contractor status?	☐ Yes ☐ No
Professional society membership or fellowship/board certification or recertification?	☐ Yes ☐ No
Any other type of professional sanction, including the **Maryland Board of Physicians**, other state agencies or similar agency including but not limited to Medicare, Medicaid, etc.?	☐ **Yes** ☐ **No**
Professional liability insurance?	☐ Yes ☐ No
Have any criminal charges been brought against you?	☐ Yes ☐ No

Name:_____

PROFESSIONAL LIABILITY INSURANCE COVERAGE

9. Please list the name, issue date and expiration date of each carrier, which has provided coverage for you **during the past 2 years**.

Insurance Company Name	Issue Date	Expiration Date
Insurance Company Name	Issue Date	Expiration Date

Please provide the following information regarding your professional liability carriers

a. Have you failed or been unable to purchase tail coverage for claims made policies from any previous insurance carriers during the past two (2) years? If yes, provide an explanation on a separate page. ☐ Yes ☐ No

b. Has your professional liability insurance coverage been limited, revoked or not renewed by any company, medical society, or organization the past two (2) years? If yes, provide an explanation on a separate page. ☐ Yes ☐ No

c. Does your professional liability insurance policy contain any exclusion, limitation or reservation relating to any procedure or medical care for which you are requesting clinical privileges? If yes, provide an explanation on a separate page. ☐ Yes ☐ No

d. During the past two (2) years, have there been any claims, suits, settlements or arbitration procedures involving your professional practice? If yes, see below. * ☐ Yes ☐ No

e. Are there currently pending any claims, suits, settlements or arbitration procedures involving your professional practice? If yes, see below. * ☐ Yes ☐ No

****NOTE:*** Provide an explanation on a separate sheet. Please state the status of each claim, capacity in which you were involved, names of parties, state, court and year in which suit was filed and full name of primary attorney. Include whether the claim has been to arbitration, specifying the health care arbitration number, date, current status and final outcome as well as any court case number.

REAPPOINTMENT APPLICATION REQUIREMENTS

In consideration of the hospitals' agreement to receive, review and process your reappointment application (Reappointment), you are required to sign this statement so that we may secure information in good faith that will enable us to make an informed decision on your Reappointment for privileges.

The following Permission, Pledge, and Release and Indemnification shall continue in force for all matters in connection with the grant, denial, approval, reapproval, removal, suspension, termination, and withdrawal of your medical staff appointment and clinical privileges at any hospital affiliated with MedStar Health, including the ongoing sharing of utilization review and quality assurance information among all organizations affiliated with MedStar Health.

PERMISSION TO OBTAIN INFORMATION

I give my consent and permission to each hospital affiliated with MedStar Health, its agents, employees, and medical staff appointees to contact other MedStar Health hospitals and non-MedStar Health hospitals, affiliations, professional societies, medical schools, licensing bodies, professional review organizations, professional malpractice insurance carriers, named references, state and federal agencies, and other individuals and organizations the hospitals deem necessary for the purpose of inspecting all records and documents pertaining to my licensure, medical training, experience, current competency and claims experience, including the sharing of utilization review and quality assurance information of any organization affiliated with MedStar Health. I agree to appear for an interview in connection with the processing of my Reappointment for medical staff appointment or request for clinical privileges should the chairperson or division head request an interview.

PLEDGE

I pledge and agree that if I am granted medical staff reappointment or clinical privileges at any of the hospitals affiliated with MedStar Health, I will provide for continuous care of my patients at the hospitals. I will abide by the respective provisions of the medical staff bylaws, and rules, regulations, protocols and policies adopted by the respective hospital, medical staff or by the department to which I am assigned.

RELEASE

In consideration of the MedStar Health affiliated entities' agreement to receive and process my application for appointment and clinical privileges, I release from liability and grant immunity to each hospital, institution, physician, law enforcement agency or other person who acts in good faith or provides information in good faith to MedStar Health and its affiliated entities in connection with my application for appointment and clinical privileges. In consideration of the MedStar Health affiliated entities' agreement to receive and process my application for appointment and clinical privileges, I also release from liability and grant immunity to MedStar Health and persons affiliated with MedStar Health (including its affiliated entities, facilities, board members, agents, employees and medical staff) for any actions taken by them in good faith in connection with my application for appointment and clinical privileges.

I agree to exhaust the administrative procedures afforded to me by MedStar Health's affiliated entities prior to resorting to formal legal action if an adverse ruling is made with respect to my clinical privileges or medical staff membership.

(Electronic) By typing my name below, I certify the above statements to be true and correct to the best of my knowledge, and that this information can be used for the purpose of processing my MedStar Union Memorial Hospital Reappointment Application. **(Non-Electronic)** If filling out the application by hand, please provide your original signature and date.

_____ _____

Signature of Applicant Date

MEDSTAR HEALTH, 10/23/98; revised 6/28/99; 8/18/00

reappt.

CONDITIONS OF REAPPOINTMENT

I. In regard to the filing of this medical staff reappointment application and clinical privileges (Reappointment) at any of the hospitals affiliated with MedStar Health, I understand and agree to the following:

(a) I do not have any right to practice medicine nor will I have any clinical privileges at any hospitals affiliated with MedStar Health, beyond the term of my prior appointment until such time as I have been notified in writing that my reappointment and delineation of clinical privileges have been approved by the board(s) of the hospital(s).

(b) If requested, I will schedule a personal interview with the appropriate department chairperson or section chief and comply with any requests for information from the credentials committees, the executive committees of the medical staffs and the boards.

(c) If requested, I will complete and sign any request for release of my medical records.

II. If my reappointment at a hospital is approved, I understand and agree to the following:

(a) I must abide by the provisions of the medical staff bylaws, and by rules, regulations policies and protocols adopted by that medical staff or by the clinical department in which I have delineated privileges as adopted by a department or the hospital.

(b) I will actively participate in the administration of the medical staff's affairs and the educational programs of the hospital to which I am reappointed.

(c) I will perform only those procedures for which I have requested and been granted clinical privileges at the hospital.

(d) The approval of the hospital is based in part on my representations in this reappointment, and that the approval may be revoked or withdrawn by the hospital at any time upon discovery of any misrepresentation or material omission in my initial application or any subsequent Reappointment.

(e) Before commencing any clinical practice at the hospital, it is my responsibility to file evidence of professional liability insurance with the medical staff office of the hospital.

(f) Reappointment and reprivileging will be conditioned upon my continued compliance with the qualifications and criteria as outlined in the medical staff bylaws.

(g) I am responsible for the care of the patients that are admitted to my service. The hospital will provide physician assistants and physicians for onsite care of my patients, if I so choose. If I so choose to utilize this service, I am responsible for supervising the medical care. The hospital remains responsible for the competence and credentials of these individuals acting under my direction and clinical supervision.

(h) I have a continuing obligation to the hospital to report (to the medical staff office) any subsequent occurrences; incidents, actions, or other information related to my reappointment which occur following the filing of this Reappointment or its approval.

(i) If any of my medical staff reappointments or delineation of clinical privileges is conditioned upon specialty board certification, employment or some other condition, I will notify the hospital's medical staff office if I fail to meet the condition at any time.

(j) I will submit copies of all license renewals as received and a certificate of insurance as renewed annually.

(l) If any medical staff office within MedStar Health determines that I have lied or misrepresented any information on my initial application or Reappointment, this determination will be sufficient grounds for immediate termination of my appointment to the hospital's medical staff.

(m) In consideration of the hospital's agreement to receive and process this Reappointment, I agree to comply with or grant the Reappointment Application Requirements attached to and incorporated in this Reappointment.

(n) I authorize the disclosure of information gathered in connection with my Reappointment, and the ongoing review of my privileges between and among the medical review committees of the hospital and other entities within MedStar Health, in light of my recognition of the affiliated status of the hospital and other health care entities within MedStar Health.

(Electronic) By typing my name below, I certify the above statements to be true and correct to the best of my knowledge, and that this information can be used for the purpose of processing my MedStar Union Memorial Hospital Reappointment Application. **(Non-Electronic)** If filling out the application by hand, please provide your original signature and date.

_____ _____

Signature of Applicant Date

MEDSTAR HEALTH, 10/23/98; 10/19/99; 8/18/00

MEDSTAR UNION MEMORIAL HOSPITAL POLICY
APPLICATION FOR
MODERATE SEDATION PRIVLEGES

I am applying/reapplying for privileges to administer moderate sedation at MedStar Union Memorial Hospital. I affirm that I am familiar with the hospital's Moderate Sedation Policy and agree to abide by it. The hospital's Moderate Sedation policy is available in the Department of Anesthesia and on the Pharmacy website within StarPort under Clinical Guidelines and Policy and Procedures. To request a copy please call 410-554-6497.

To support my application I am enclosing: **(PLEASE NOTE NEW REQUIREMENTS)**

☐ A copy of my current ACLS, ATLS or PALS certification

and

A copy of my certificate from the Anesthesia Department that I have reviewed the educational video and have passed the post-test within the past two years.

or

☐ I am applying based on my residency or fellowship training in airway management and moderate sedation. (Applies to: Pulmonologists, ER physicians and Oral surgeons).

or

☐ Current moderate sedation privileges from other MedStar Hospital

☐ **I am not requesting Moderate Sedation privileges at this time (Please sign and date)**

(Electronic) By typing my name below, I certify the above statements to be true and correct to the best of my knowledge, and that this information can be used for the purpose of processing my MedStar Union Memorial Hospital Moderate Sedation Application. **(Non-Electronic)** If filling out the Moderate Sedation application by hand, please provide your original signature and date.

_____ _____
Signature Date

Please complete and forward to your Department Chief at MUMH for approval.

_____ _____
MUMH Department Chief Date

Approved MEC 1/9/06
Revised 12/9/10
Revised 5/8/11
Approved MEC 7/11/11
Approved PPQOC 8/18/11