

CRNA APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

(Use additional sheets where necessary for additional space)

Hospital	Location	Date					
IDENTIFYING INFORMATION	Last Name	First Name	Initial	SSN	Birthplace	Date of Birth	
	Office Address		City	State	Zip Code	Area Code	Telephone
	Home Address		City	State	Zip Code	Area Code	Telephone
	Citizenship			Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D		Name of Spouse	
	Practice Limited to						
	Other Medical Interests in Practice, Research, Etc.						
	Practicing with Whom and Nature of Affiliation						
MEDICAL INFORMATION	On separate sheet, furnish date of last physical examination, significant findings, name of physician and/or institution where performed, ar dates and causes of all hospitalizations for past five years.						
PREMEDICAL EDUCATION	College or University			Degree		Honors	
	Address					Date of Graduation	
MEDICAL EDUCATION	Medical School			Degree		Honors	
	Address					Date of Graduation	
CONTINUING MEDICAL EDUCATION	On separate sheet, list all Postgraduate activities which you have attended, or for which you have received credit in the past two years.						
	Furnish a list of Scientific Papers or Essays you have written, and a list of Scientific Meetings you have attended during previous three years (include reprints).						
AFFILIATIONS	Present capacity with this hospital					Dates	
	List all present and previous hospital affiliations and medical staff memberships, in chronological order (include assistantships and appointments). Specify all departments in which privileges were exercised and nature and extent of such privileges.						
	Name and location of hospital				Capacity	Dates	
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DESCRIPTION OF PRACTICE	On separate sheet, give narrative summary of all past and present medical practice including office, clinic, hospital and military.						
MEMBERSHIP IN PROFESSIONAL SOCIETIES	Are you a member of the _____ County Medical Association?					<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have an application pending?					<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you intend to apply?					<input type="checkbox"/> Yes <input type="checkbox"/> No	
If member past or present or applicant to other county, state or national society, give name							
FELLOWSHIP	American College of					Date	
	American College of					Date	
	Member of American Academy of Family Practice?					<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Fellowship in other specialty colleges						
CERTIFICATION	Certified by American Board of (Name of Board)					Date	
	Board Qualified (Name of Board)					Date	
	Specialty Board status (Name of Board)			Are you certified?		Date	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
If not certified, give present status							
LICENSING	Medical license (Name of state and county)			Date	License No.	Registration No.	
	Federal Narcotics Registration Number					Date	
	Other (Nature of License, County and State)					Date	License N
MEDICAL	If possible, include two members of _____ hospital medical staff, other than those who might be listed under 'affiliations. Note: References will be evaluated primarily by the extent of direct clinical observation and other work with the applica						

REFERENCES	Doctor		Address		
	Doctor		Address		
	Doctor		Address		
	Doctor		Address		
LIABILITY INSURANCE	Amount of coverage		Insurance carrier		Expiration date
	Policy No.		Agent		
	On separate sheet, list all previous insurance carriers, amount of coverage and dates.				
	Have judgments or settlements been made against you in professional liability cases, or are there any pending? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'yes', give details on separate sheet				
IF ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS 'YES', PLEASE GIVE FULL DETAILS ON SEPARATE SHEET OF PAPER.					
A. Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked?					<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Have you ever been refused membership on a hospital medical staff?					<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Has your request for any specific clinical privilege ever been denied or granted with stated limitations?					<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Have your privileges at any hospital ever been suspended, diminished, revoked or not renewed?					<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Has your narcotics registration ever been suspended or revoked?					<input type="checkbox"/> Yes <input type="checkbox"/> No
F. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization?					<input type="checkbox"/> Yes <input type="checkbox"/> No
I HEREBY APPLY TO THE HOSPITAL FOR APPOINTMENT	<input type="checkbox"/> To the attending staff in the department of _____				
	<input type="checkbox"/> To the consulting staff assigned in the department of _____				
	<input type="checkbox"/> Other (specify) _____				
PRIVILEGES DESIRED	<input type="checkbox"/> Medical <input type="checkbox"/> Surgical <input type="checkbox"/> Obstetrical <input type="checkbox"/> Gynecological <input type="checkbox"/> Pediatric <input type="checkbox"/> Orthopedic <input type="checkbox"/> Dental				
	<input type="checkbox"/> Other (Specify) _____				
	<input type="checkbox"/> Special procedures (Specify) _____				
	<input type="checkbox"/> Specialty or sub-specialty consultation (Specify) _____				

I fully understand that any significant mis-statements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true to my best knowledge and belief.

In making this application for appointment to the medical staff of this hospital, I acknowledge that I have received and read the by-laws of the hospital and the by-laws, rules and regulations of the medical staff of this hospital, and that I am familiar with the principles and standards of the Joint Commission on Accreditation of Hospitals and the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty and/or profession, and I agree to be bound by the terms thereof if I am granted membership or clinical privileges, and I further agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment to the medical staff, and I further agree to abide by such hospital and staff rules and regulations as may be from time to time enacted.

By applying for appointment to the medical staff I hereby signify my willingness to appear for the interviews in regard to my application, authorize the hospital, its medical staff and their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the hospital, its medical staff and its representatives of all records and documents, including medical records, at other hospitals, 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 staff membership. I hereby release from liability all representatives of the hospital and its medical staff 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 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 hereby further authorize and consent to the release of information by this hospital, or its medical staff, to other hospitals, medical associations and other interested persons on request regarding any information the hospital and the medical staff 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 this hospital and its staff for so doing.

I understand and agree that I, as an applicant for medical staff membership, 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.

I will not participate in any form of fee-splitting. Moreover, I pledge myself to shun unwarranted publicity, dishonest money-seeking, and commercialism; to refuse money trades with consultants, practitioners, makers of surgical appliances and optical instruments, or others; to teach the patient his financial duty to the physician and to expect the practitioner to obtain his compensation directly from the patient; to make my fees commensurate with the service rendered and with the patient's rights; and to avoid discrediting my associates by taking unwarranted compensation.

I have not requested privileges for any procedures for which I am not certified. Furthermore, I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have requested privileges.

Signature of Applicant

Appointment Recommended Appointment Not Recommended Appointment Deferred

Date

Chairman, Credentials Committee

Appointment Recommended Appointment Not Recommended Appointment Deferred

Date

Chairman, Executive Committee

Appointment Recommended Appointment Not Recommended Appointment Deferred

Date

President, Medical Staff

Appointment

Disapproved

Deferred

Date

Secretary, Governing Board

Remarks: