APPLICATION FOR STAFF MEMBERSHIP

A. PERSONAL INFORMATION

1. Name and Locations

(Please Print) Last First Middle Social Security Number

Home Address No. and Street City State Zip Telephone

Office Address No. and Street City State Zip Telephone

Date of Birth:_____ Birthplace:_____

2. Education

	School Name and Location	Degree	Dates Attended
Undergraduate:			
Professional:			
Other Graduate:			
(Residencies/Fellowships)			

B. LICENSES AND REGISTRATIONS

1. License

State	Number	Expiration Date

2. DEA Registration

Number_____

C. BOARD CERTIFICATIONS

Specialty _____

Eligible ___
Certified ___
Fellow ___

D. HOSPITAL AFFILIATIONS

Hospital Name _____ City/State _____

Hospital Name _____ City/State _____

E. LIABILITY INSURANCE

Company _____

Coverage Limits _____ Expiration Date _____

Have judgments or settlements been made against you in professional liability cases, or are there any pending? Yes_____ No_____ If so, attach a separate sheet with details.

F. DISCIPLINARY ACTIONS

Have any of the following ever been or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? If yes, please provide full explanations on a separate sheet.

Nursing, Dental or Medical License in any state	Yes___	No___
Any other professional registration/license	Yes___	No___
DEA registration	Yes___	No___
Academic appointment	Yes___	No___
Membership on any ambulatory surgery center of hospital staff	Yes___	No___
Clinical privileges	Yes___	No___
Prerogatives/rights on any medical staff	Yes___	No___
Professional society membership or fellowship/Board Certification	Yes___	No___
Professional office	Yes___	No___
Any other type of professional sanction	Yes___	No___
Professional liability insurance	Yes___	No___
Have there been any felony charges brought against you in the past?	Yes___	No___
Have you had an illness or physical disability that impairs, or could impair your ability to practice your specialty?	Yes___	No___
Have you ever had a chemical dependency problem 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, please provide full explanation on a separate sheet, including resolution of charges or actions.

G. SURGICAL SPECIALTY AND CLINICAL PRIVILEGES

1. Surgical Specialty

The surgical specialties which I request privileges include the following:

Endodontics	____	Oral Surgery	____	Pediatric Dentistry	____
General Dentistry	____	Periodontics	____	Anesthesiology	____

Other (please explain) _____

2. Clinical Privileges

My request for privileges includes all clinical procedures generally accepted and associated within the above noted specialties, plus these additional procedures.

_____ _____

_____ _____

3. Peer References

In the space provided below please list two peer references that are able to comment on your clinical skills and ethics.

Name: _____ Phone: _____

Address: _____ City/State: _____

Name: _____ Phone: _____

Address: _____ City/State: _____

H. AFFIDAVIT

I hereby release from liability all representatives of **Minnie Street Surgery Center** along with its CRNA, Dental, and Physician Staff for their acts performed in good faith and without malice in connection with the evaluation of my application and credentials and qualifications in the credentialing decision.

I hereby release from any liability to all individuals and organizations who provide information to **Minnie Street Surgery Center, LLC,** and its Staff in good faith, and without malice concerning licensure, education and training, experience, current competence, physical and mental health status, ability to cooperate with others, malpractice claims experience, ethical qualifications and other qualifications for staff appointment and clinical privileges.

I hereby consent to the release of such information**.**

In addition, I agree to notify the Organization of any circumstances that would change my status in licensure, DEA, Medicaid, CHIP, Medicare participation, liability insurance coverage or Board certification status or hospital privileges.

By signing this statement, I affirm that the information provided on this application and any required accompanying documentation is accurate and complete. I understand that falsification of information requested by Minnie Street Surgery Center is grounds for denial of certification/re-certification.

_____ _____

Signature of Applicant Date