



REAPPOINTMENT TO THE MEDICAL STAFF

PLEASE TYPE OR PRINT ALL INFORMATION

Name _____ Physician ID#: _____

National Provider Identifier (NPI) _____ HIPAA Taxonomy Code(s) _____

Primary Office: _____

Address City State Zip

Area Code Phone Number Fax Number

Secondary Office: _____

Address City State Zip

Area Code Phone Number Fax Number

Email Address: _____

Cell Phone #: _____ Pager #: _____

Answering Service company: _____ Phone _____

Home Address: _____

Address City State Zip

Phone Number (Your home address and phone # will not be published)

1. CONTINUING MEDICAL EDUCATION

What is your total number of CME hours (Category 1) in the past 2 years? _____

What percentage of these hours relate to your specialty? _____ %

2. CARDIOPULMONARY RESUSCITATION: (Required for Emergency Department Physicians, General Surgeons, and Pediatric Surgeons participating in the Trauma program). Please attach copies:

- BLS certification expiration date _____
BCLS certification expiration date _____
ACLS certification expiration date _____
ATLS certification expiration date _____
PALS certification expiration date _____

Name: _____

3. **PROFESSIONAL RECOGNITION** (*Offices Held, Honors*):

4. **SPECIALTY STATUS:**

Please note that the Medical Staff Bylaws of MRH/JDCH, MHW, MHP and MHM require that new applicants become Board Certified within 5 years of appointment. Additionally, the bylaws require that you maintain certification.

Board Certification – Name of Board: _____

Year Certified: _____ Year of Recertification: _____

Subspecialty Board – Name of Board: _____

Year Certified: _____ Year of Recertification: _____

Any added Qualifications: _____

If not Board Certified, are you currently eligible to sit for Board Examination? Yes _____ No _____

If yes, projected examination date: _____

If no, when will you be eligible to sit for examination? _____

5. **TEACHING APPOINTMENTS:**

Position Held: _____ From _____ To _____

Facility – Name and Address: _____

6. **Has the nature of your Medical Staff practice changed since your last reappointment to the Medical Staff?**

(If "Yes", please explain on a separate sheet.) _____ Yes _____ No

7. **Since your last reappointment, have any actions occurred with regard to your professional license, your DEA registration, or have either been limited, suspended, or revoked or are there any currently pending challenges to any licensure or registration?**

(If "Yes", please explain on a separate sheet.) _____ Yes _____ No

Name: _____

8. **Since your last reappointment, has there been any voluntary or involuntary relinquishment of any license to practice medicine or registration?**

(If "Yes", please explain on a separate sheet.) _____ **Yes** _____ **No**

9. **Since your last reappointment, has your Medical Staff Status, or any other type of affiliation at any healthcare entity been limited, reduced, suspended, revoked, not renewed, or subject to probationary conditions, or have proceedings toward any of these ends been instituted, recommended or are you current under investigation by any healthcare entity?**

(If "Yes", please explain on a separate sheet.) _____ **Yes** _____ **No**

10. **Since your last reappointment, have you voluntarily relinquished any membership, clinical privileges, or affiliation with any healthcare entity while under investigation, threat of investigation, or threat of disciplinary action?**

(If "Yes", please explain on a separate sheet.) _____ **Yes** _____ **No**

11. **Since your last reappointment, have you been denied membership or renewal thereof or been subject to any disciplinary action in any medical organization, or professional society, local or state, including any professional review organization or are you current under review?**

(If "Yes", please explain on a separate sheet.) _____ **Yes** _____ **No**

12. **Since your last reappointment, have you been convicted of a felony, or are there any felony proceedings, indictments, or investigations presently pending?**

(If "Yes", please explain on a separate sheet.) _____ **Yes** _____ **No**

13. **Since your last reappointment, have you had any physical or mental illness, which may impair your ability to practice within the scope of privileges requested?**

(If "Yes", please explain on a separate sheet.) _____ **Yes** _____ **No**

14. **Have you undergone treatment for alcohol or drug dependence in the past two years or are you currently undergoing treatment?**

(If "Yes", please explain on a separate sheet.) _____ **Yes** _____ **No**

Name: _____

15. Since your last reappointment, have you been denied professional liability insurance coverage, in whole or in part, or has your policy been cancelled, involuntarily restricted, denied renewal, or rated up because of the nature or volume of claims against you?

(If "Yes", please explain on a separate sheet.) _____ Yes _____ No

16. Since your last reappointment, have you been a defendant in a malpractice/professional liability suit, have you received written notice of intent to file such a suit, or have there been any claims settled or judgments against you?

(If "Yes", please explain on a separate sheet.) _____ Yes _____ No

17. Please list the hospital(s) where you currently hold active Medical Staff Membership (other than those that are a part of the Memorial Healthcare System.)

18. Please review your current delineation of privilege form that is attached and complete the new form provided. Please note that any request for privileges not previously held must be accompanied by documentation of your training and/or experience to substantiate the request.

Are you requesting any new privileges? _____ Yes* _____ No

If so, what new privileges:

** Please attach proof of competency, i.e. documentation of training (applicable certificate/letter from director of Training) and/or cases performed.*

With my signature, I certify the accuracy of the above data. I agree to report any changes in my health status that would affect my ability to practice medicine, and I agree to submit to a physical examination acceptable to the Credentials Committee or the Executive Committee should this be considered necessary. I also agree to adhere to the provisions of the Medical Staff Bylaws and the Rules and Regulations of the Medical Staff and my department. I fully understand that any misstatements in, or omissions from this application may constitute cause for dismissal from the Medical Staff.

Signature of Physician

Date

Name: _____

ATTACHMENT A
MALPRACTICE ACTIONS

Case Name – Plaintiff vs. Physician _____

Name of Insurance Carrier _____

Were you the primary physician on this case? _____ **Yes** _____ **No**

If no, what was your role in caring for this patient? _____

Date of Incident _____ Place of Incident _____

Date Suit Commenced: _____ Status (check one) Pending Closed

Substance of Allegations:

If closed, disposition (check one) Dismissed Judgment Settled

Substance of Findings:

Case Name – Plaintiff vs. Physician _____

Name of Insurance Carrier _____

Were you the primary physician on this case? _____ **Yes** _____ **No**

If no, what was your role in caring for this patient? _____

Date of Incident _____ Place of Incident _____

Date Suit Commenced: _____ Status (check one) Pending Closed

Substance of Allegations:

If closed, disposition (check one) Dismissed Judgment Settled

Substance of Findings:

Name: _____



ATTESTATION OF FINANCIAL RESPONSIBILITY

I attest to the fact that I meet the financial responsibility requirements as outlined in Florida Statute 458.320 and/or 459-0085, which require one of the following:

Please indicate which option you have chosen and sign below.

_____ I have hospital staff privileges and I have professional liability coverage in an amount not less than \$250,000 per claim, with a minimum annual aggregate of not less than \$750,000 from an authorized insurer as defined under s.624.09, F.S., from a surplus lines insurer as defined under s.626.914(2), F.S., from a risk retention group as defined under s.627.942, F.S., from the Joint Underwriting Association established under s.627351(4), F.S., or through a plan of self insurance as provided in s.627.367, F.S.

_____ I have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of \$250,000/\$750,000, in accordance with Chapter 675, F.S., for a letter of credit and s.625.52, F. S., for an escrow account.

_____ I have elected not to carry medical malpractice insurance, however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s.458.320(5)(g)1 or 459.0085(5)(g)1, F.S. I understand that I just either post notice in the form of a “sign” prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s.458.320(5)(g) or 459.0085(5)(g), F.S. For patients treated at a facility in the Memorial Healthcare System, I will provide this written statement.

***SEE NOTE BELOW**

Print Name _____

Signature _____

Date _____

NOTE: It is the practitioner’s responsibility to notify the Florida Board of Medicine should a practitioner choose to not carry medical malpractice insurance. Notification should be made to the Florida Board of Medicine 10 days prior to such change taking effect. Notification can be made to the Florida Board of Medicine via fax to Shannon O’Connor at 850-488-0596.