

TRINITY HOSPITALS
Minot, North Dakota
MEDICAL STAFF
PRE-APPLICATION FORM



Application Instructions: Complete the application in full. The application must be typed or neatly printed. *Attach additional sheets if there is insufficient space on this application to complete your response.* Submit the completed, signed application to:

President, Trinity Hospitals, P.O. Box 5020, Minot, ND 58702-5020

PERSONAL INFORMATION

	Date of Birth _____	Place of Birth _____
Name (Last) _____	(First) _____ (Middle Initial) _____	Social Security No. _____
Office Address _____	Telephone _____	
Home Address _____	Telephone _____	

Please indicate your clinical specialty as well as any area in which you may wish to request clinical privileges.

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergy & Immunology | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Physical Medicine & Rehabilitation |
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Neonatology | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Cardiovascular Medicine | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Critical Care Medicine | <input type="checkbox"/> Neurological Surgery | <input type="checkbox"/> Pulmonary Disease |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Neurology | <input type="checkbox"/> Radiation Oncology |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Obstetrics & Gynecology | <input type="checkbox"/> Radiology & Nuclear Medicine |
| <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Family Medicine | <input type="checkbox"/> Oral & Maxillofacial Surgery | <input type="checkbox"/> Thoracic Surgery |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Orthopedic Surgery | <input type="checkbox"/> Urology |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Other <i>(please list)</i> _____ |
| <input type="checkbox"/> Hematology/Oncology | <input type="checkbox"/> Pathology | |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Pediatrics | |

CERTIFICATION: Are you American, Canadian, or Osteopathic Board certified? Yes No

Name of Board _____

Date Certified _____ Expiration _____

Name of Subspecialty Board _____

Date Certified _____ Expiration _____

If you are not board certified, what is your status in the certification process?

Have you ever taken and failed a certification examination? Yes No

If yes, please provide details. _____

PROFESSIONAL INFORMATION:

Yes No Are you or will you be affiliated with other physician(s) or group(s)? If so, who?

To what extent do you anticipate using the facilities at Trinity Hospitals:

Percentage of your total practice: _____ Percentage of your total hospital practice: _____

Yes No Will your office and residence be geographically located to allow you to provide continuous care for your patients?

Please indicate the date your office will open _____

In chronological order, please list all hospitals at which you have held clinical privileges during the last five years. ***Please attach separate page, if needed.***

Hospital: _____

Address: _____
Street City, State Zip

Dates of Affiliation: _____

Contact Person: _____

Hospital: _____

Address: _____
Street City, State Zip

Dates of Affiliation: _____

Contact Person: _____

Hospital: _____

Address: _____
Street City, State Zip

Dates of Affiliation: _____

Contact Person: _____

Hospital: _____

Address: _____
Street City, State Zip

Dates of Affiliation: _____

Contact Person: _____

Hospital: _____

Address: _____
Street City, State Zip

Dates of Affiliation: _____

Contact Person: _____

PROFESSIONAL LIABILITY INSURANCE: Present Carrier: _____ Limits of Coverage: \$ _____
 Address: _____
 Agent: _____ Exp. Date _____
 Phone No. _____ Policy No. _____

Yes No Have there been or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice? *If "YES", please provide (on separate sheet) list indicating for each the date the suit was started, the name and location of the court, the names of the parties, a brief description of the amount and nature of the claim, and the final judgments or settlements involving the individual.*

DISCIPLINARY ACTION: 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? Or, have you withdrawn or failed to proceed with an application for any of the following? *If "YES", please provide full explanation on a separate sheet.*

- Yes No Medical license or other professional registration/license in any state
- Yes No DEA controlled substance registration
- Yes No Membership on any hospital medical staff/Clinical privileges at any hospital
- Yes No Prerogatives/rights on any medical staff
- Yes No Other institutional affiliation or status thereat
- Yes No Professional society membership or fellowship/board certification
- Yes No Any other type of professional sanction
- Yes No Professional liability insurance
- Yes No Has there ever been any felony or misdemeanor criminal charges brought against you?

The following are prerequisites for receiving an application and copies **MUST** be returned with this form.

- a. Current license to practice medicine in the State of North Dakota
- b. Current Federal DEA Registration certificate
- c. Certificate of professional liability insurance coverage
- d. ECFMG certificate (if foreign medical graduate)
- e. Medical Diploma
- f. Internship/Residency/Fellowship certificates
- g. Evidence of board certification status
- h. A complete curriculum vitae
- i. Evidence of tuberculin skin test or chest x-ray (**must** be within the last 12 months). Evidence has to be provided prior to the first day of employment and/or granting or privileges.

I certify that my statements in this pre-application questionnaire are accurate and the enclosed documents are copies of authentic documents. I understand that completing this questionnaire in no way obligates the hospital and/or medical staff to grant me medical staff membership or privileges.

I request an application for appointment to the Trinity Medical Staff.

Date

Signature

See Release Form on back page

TRINITY HOSPITALS
MEDICAL STAFF PRE-APPLICATION
RELEASE OF LIABILITY AND PRACTITIONER'S STATEMENT

I hereby:

- Authorize the Hospital, its Medical Staff, and their representatives to consult with members of the Governing Bodies and Medical Staffs of other hospitals, with which I have been associated, and with others who may have information bearing on my professional competence, character, ethical qualifications, health status, ability to work cooperatively with others, and other qualifications for staff appointment and/or clinical privileges;
- Consent to the inspection by the Hospital, its Medical Staff, and their representatives of all documents that may be material to an evaluation of my qualifications and competence;
- Consent to the release of such information;
- Release from liability all representatives of the Hospital and its Medical Staff and their representatives for their acts performed and statements made in good faith and without malice in connection with evaluating my credentials and qualifications.
- Release from liability any and all individuals and organizations who provide information to the Hospital and its Medical Staff and their representatives, in good faith and without malice, concerning my professional character, ethics, health status, ability to work cooperatively with others, and other qualifications for staff appointment and/or clinical privileges.

Date

Signature

Name: Printed or Typed