

TRINITY HEALTH
Minot, North Dakota
MEDICAL STAFF
ELIGIBILITY & MEMBERSHIP
SCREENING 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:

Administration - Medical Staff Services, Trinity Health, P.O. Box 5020, Minot, ND 58702-5020

PERSONAL INFORMATION:

	_____	_____	
	Date of Birth	Place of Birth	
Name (Last)	(First)	(Middle Initial)	Social Security Number
Office Address			Telephone
Home Address			Telephone
Email Address			Cell Phone

Primary Speciality: _____
Secondary Speciality (If applicable): _____

USMLE: Do you meet the ND Board of Medical Examiners requirement for completing USMLE within 7 years and with no more than 3 attempts per step? Yes No

Step 1: Attempts: _____ Date Passed: _____
Step 2: Attempts: _____ Date Passed: _____
Step 3: Attempts: _____ Date Passed: _____

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. _____

MEDICAL SCHOOL:

Institution _____			
Address	Street	City, State	Zip
		to	
Degree	Dates Attended (Mo./Yr.)	Date Graduated (Mo./Yr.)	

PROFESSIONAL INFORMATION:

Yes No Will you be employed by Trinity Health

If no – please answer the following questions: describe your practice plan, office location, and expected use of Trinity Health. _____

EMPLOYMENT HISTORY:

In chronological order, please list your employment history for the past five years. Include any independent practice.

(Please attach separate page, if needed)

Organization Name: _____

Address: _____
Street City, State Zip

Phone: _____ Fax: _____

Still Open? Yes No

Dates of Employment: _____
month/year to month/year

Organization Name: _____

Address: _____
Street City, State Zip

Phone: _____ Fax: _____

Still Open? Yes No Dates of Employment: _____
month/year to month/year

Organization Name: _____

Address: _____
Street City, State Zip

Phone: _____ Fax: _____

Still Open? Yes No Dates of Employment: _____
month/year to month/year

HOSPITAL AFFILIATIONS:

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: _____
month/year to month/year

Contact Person/Medical Staff Office: _____ Phone: _____

Department Physician Chairperson: _____ Phone: _____

Hospital: _____

Address: _____
Street City, State Zip

Dates of Affiliation: _____
month/year to month/year

Contact Person/Medical Staff Office: _____ Phone: _____

Department Physician Chairperson: _____ Phone: _____

Hospital: _____

Address: _____
Street City, State Zip

Dates of Affiliation: _____
month/year to month/year

Contact Person/Medical Staff Office: _____ Phone: _____

Department Physician Chairperson: _____ Phone: _____

DISCIPLINARY ACTIONS AND PRACTICE HISTORY:

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, voluntarily or involuntarily relinquished, or have you ever withdrawn or failed to proceed with an application for any of the following? If "YES", please give full details on an additional page.

- Yes No Medical license in any state
- Yes No Other professional registration/license
- Yes No DEA/controlled substance registration
- Yes No Academic appointment
- Yes No Membership on any hospital medical staff
- Yes No Clinical privileges
- 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 sanctions
- Yes No Professional liability insurance
- Yes No Are there any charges pending or are you currently charged with or have you ever pled guilty, been indicted or found guilty of a felony, gross misdemeanor, misdemeanor (other than a minor traffic violation), or other offense?
- Yes No To your knowledge, have you ever been the subject of an individual focused review required by PSRO, PRO, or similar agency?
- Yes No Have you ever been formally charged with infractions or professional misconduct by the licensing authority of any licensing jurisdiction?
- Yes No Has your employment or other relationship with an HMO, PPO, IPA, or other alternative health delivery system ever been denied, suspended, revoked, limited, or restricted?
- Yes No Have you ever been charged with or convicted of any crime related to your clinical practice, including Medicare or Medicaid related crimes; have you ever been subjected to civil money penalties under the Medicare or Medicaid program; have you been suspended from participation in Medicare or Medicaid?
- Yes No Have you ever been involuntarily terminated or forced to resign, or have you ever resigned voluntarily while under investigation or threat of sanction, from a clinical position with the armed forces, or any federal, state, or local agency or any other employment or practice arrangement?

HEALTH STATUS:

If you answer "YES" to any of the following questions, please give full details on an additional page.

- Yes No Do you have a physical or mental condition or substance abuse problem that could affect your ability to exercise the clinical privileges requested or that would require an accommodation for you to exercise those privileges safely and competently?
- Yes No Are you currently taking medication and/or under other therapy for a condition which could affect your ability to perform professional or medical staff duties if it were discontinued today?
- Yes No Have you at any time during the last ten years been hospitalized or received any other type of institutional care for a health problem?
- Yes No Have you missed thirty (30) or more consecutive days of work or training during the preceding five years due to illness, injury, or health condition?

Most recent physical examination:

Date: _____ Performed by: _____

Significant findings that may affect job performance: _____

Proof of a **Quantiferon Gold TB** test prior to your anticipated start date **is required**. This test must have been administered within the last 12 months. If not available, test will be administered at Trinity on or before your start date.

PROFESSIONAL LIABILITY HISTORY:

If you answer "YES" to any of the following questions, please give full details on an additional page indicating for each the date any litigation or arbitration was started, the name and location of the court or arbitration panel, the names of the parties, a brief description of the nature of the claim, and the current status.

- Yes No Have there been or are there currently pending any liability claims, suits, or arbitration proceedings against you or involving your professional practice?
- Yes No Has any judgment or arbitration award been entered against you in any professional liability case?
- Yes No Has any settlement been made in any professional liability case in which you or your professional liability insurance carrier had to or agreed to make a monetary payment?
- Yes No Have you been denied professional liability insurance?
- Yes No Have you ever had a professional liability insurance policy cancelled?
- Yes No Have you ever had a professional liability insurer refuse to renew your policy or place limitations on the scope of your coverage?
- Yes No Has any professional liability carrier expressed an intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage?

MEDICAL LICENSES:

State	Number	Current?	Expiration Date
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Yes No Are you legally eligible to work in the United States?

If you are a foreign medical school graduate, have you passed the ECFMG examination?

Yes No ECFMG Number _____

**TRINITY HEALTH
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.

May we contact your current Employer/Department Chairperson/Residency

Director? Yes No

If no, please state reason why _____

Date

Signature

Name: Printed or Typed