TRINITY HEALTH
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:

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 _____

Degree _____ Dates Attended (Mo./Yr.) _____ to _____ Date Graduated (Mo./Yr.) _____

PROFESSIONAL INFORMATION:

☐ Yes ☐ No *Will you be employed by Trinity Health*

If no – please answer the following questions:

Are you or will you be affiliated with other physician(s) or group(s). If so — who?_____

_____

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

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

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

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 Have there ever been any felony or misdemeanor criminal charges brought against you?

☐ 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?

☐ Yes ☐ No Have you ever been on any medication for thirty (30) or more consecutive days during the preceding five years which prevented you from performing professional or medical staff duties?

☐ Yes ☐ No Have you taken sick leave or a leave of absence of two or more weeks during the preceding
five years?

☐ Yes ☐ No Have you applied for or received health related benefits under workers' compensation or any public or private disability benefit or disability insurance program?

Most recent physical examination:
Date: _____ Performed by: _____

Significant findings:_____

_____

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
_____	_____	☐ Yes ☐ No	_____
_____	_____	☐ Yes ☐ No	_____
_____	_____	☐ Yes ☐ No	_____
_____	_____	☐ Yes ☐ No	_____
_____	_____	☐ Yes ☐ No	_____
_____	_____	☐ Yes ☐ No	_____

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

☐ Yes ☐ No ECFMG Number_____

The following are prerequisites for final approval of your privileges, and can be submitted at this time if available.

a. Current license to practice medicine in the State of current medical practice
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 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.

_____

Date Signature

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