Memorial Healthcare System

3501 Johnson Street
Hollywood, Florida 33021
954-987-2020 Ext 5340

APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

Memorial Regional Hospital (MRH)	☐ Provisional	☐ Courtesy	
Memorial Hospital West (MHW)	☐ Provisional	☐ Courtesy	
Memorial Hospital Pembroke (MHP)	☐ Provisional	☐ Courtesy	
Joe DiMaggio Children's Hospital (JDCH)	☐ Provisional	☐ Courtesy	☐ Affiliate*
Memorial Hospital Miramar (MHM)	☐ Provisional	☐ Courtesy	

PLEASE TYPE OR PRINT ALL INFORMATION

APPLICANT'S NAME: ______________________________
Last Name First Name Middle Initial Maiden Name

E-mail Address: ______________________________

Cell Phone #: ____________________ Pager #: ____________________

PRIMARY OFFICE: ______________________________
Address City State Zip

____________________ ____________________
Area Code & Phone Number Fax Number

SECONDARY OFFICE: ______________________________
Address City State Zip

____________________ ____________________
Area Code & Phone Number Fax Number

ANSWERING SERVICE COMPANY: ____________________ **PHONE:** ____________

HOME ADDRESS: ______________________________
Address City State Zip

____________________ (Your home address and phone # will not be published)
Area Code & Phone Number

Place of Birth: ____________________ Date of Birth: ____________________

Citizenship: ____________________ Date: ____________________

Social Security #: ____________________ Military Status: ____________________

Medicare Provider #: ____________ Medicaid Provider #: ____________ UPIN #: ____________

Group Name: ______________________________

Please list the name(s) of your associates: ______________________________

Florida Professional License #: ____________________ Date Issued: ____________

Please list all other State Professional licenses (current and inactive):

State: ________ License #: ____________________ Date Issued: ____________

State: ________ License #: ____________________ Date Issued: ____________

***For JDCH Affiliate Staff Only**: Please state the name of the member of the JDCH Medical Staff who will be co-admitting your patients:* ______________________________

ECFMG Certificate #: ______________________ Date Issued: ______________

Board Certification - Name of Board: ______________________________

Year Certified: ______________________ Year of Recertification: ______________

Specialty Board: ______________ Year Certified: ________ Year of Recertification: ________

Any Added Qualifications: ______________________________

If not Board Certified, are your 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? ______________________________

PLEASE NOTE: The Medical Staff Bylaws of MRH, MHW, MHP, JDCH and MHM require Board Certification within 5 years of staff appointment.

DEA #: ______________________________

If no number at present, have you ever had a number previously? Yes _____ No _____

Have you ever been denied a narcotic license? Yes _____ No _____
If yes, please explain on a separate sheet

Have you had any denial, restriction, limitation, suspension, or revocation of licensure to practice medicine in any jurisdiction? Yes _____ No _____
If yes, please complete **Attachment A**

Are there any past or pending challenges to any licensure, certification, or registration, or any voluntary or involuntary relinquishment of such licensure or registration? Yes _____ No _____
If yes, please complete **Attachment A**

Have you ever been convicted of a felony, or are felony proceedings, indictments, or investigations presently pending? If yes, please explain on a separate sheet. Yes _____ No _____

Do you have or have you ever had any major 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 _____

Date of last physical examination: ______________________________

Name of Examining Physician: ______________________________

Have you ever undergone treatment for alcohol or drug dependence or are you currently undergoing treatment? If yes, please explain on a separate sheet. Yes _____ No _____

Have you ever previously held privileges at Memorial Regional Hospital, Memorial Hospital West, Memorial Hospital Pembroke, or the Joe DiMaggio Children's Hospital? (Circle facility or facilities.) Yes _____ No _____

PRE-MEDICAL EDUCATION

College or University ______________________________

Address: ______________________________

Date of Graduation: ______________ Degree Achieved: ______________

MEDICAL EDUCATION

Medical School Name: ______________________________

Address: ______________________________

Date of Graduation: ______________ Degree Achieved: ______________

POST-GRADUATE TRAINING (internships, residencies, fellowships)

Hospital ______________________________ From ________ To ________

Address ______________________________

Specialty ______________ Program Director ______________

Hospital ______________________________ From ________ To ________

Address ______________________________

Specialty ______________ Program Director ______________

Hospital ______________________________ From ________ To ________

Address ______________________________

Specialty ______________ Program Director ______________

Hospital ______________________________ From ________ To ________

Address ______________________________

Specialty ______________ Program Director ______________

PLEASE ACCOUNT FOR ANY GAPS IN YOUR TRAINING:

From _____ To _____ Explanation ______________________________

From _____ To _____ Explanation ______________________________

PROFESSIONAL PRACTICE HISTORY:

Please account for ALL time since completion of your training - include office, clinic and military experience and any time periods absent from practice. Use additional paper as needed.

____

Type of experience Contact Physician Complete Mailing Address / Phone Number

____

Type of experience Contact Physician Complete Mailing Address / Phone Number

TEACHING APPOINTMENTS:

Position Held:______________________________ From ___________ To ___________

Facility - Name and Address: ____

MEMBERSHIP ON OTHER HOSPITAL STAFFS - (Past and Present)
Include Name and Address - Attach separate sheet if more space is needed

Hospital ____________________________ Date Appointed: from:__________ to:__________
Address ____
Name of Chief ____________________________ Phone/Fax # ______________

Hospital ____________________________ Date Appointed: from:__________ to:__________
Address ____
Name of Chief ____________________________ Phone/Fax # ______________

Hospital ____________________________ Date Appointed: from:__________ to:__________
Address ____
Name of Chief ____________________________ Phone/Fax # ______________

Hospital ____________________________ Date Appointed: from:__________ to:__________
Address ____
Name of Chief ____________________________ Phone/Fax # ______________

Has your medical staff membership, medical staff status, or any other type of affiliation at any healthcare entity ever been limited, suspended, revoked, not renewed, or subject to probationary conditions, or have proceedings toward any of these ends ever been instituted, recommended or are you currently under investigation by any healthcare entity?
If yes, please complete **Attachment A** Yes ____ No ____

Have you ever been denied clinical privileges or affiliation with any healthcare entity, or have you ever had limitations placed on your clinical privileges?
If yes, please complete **Attachment A** Yes ____ No ____

Have you ever 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 currently under review?
If yes, please complete **Attachment A** Yes ____ No ____

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 complete **Attachment A** Yes ____ No ____

Have you ever discontinued practice for any reason (other than routine vacation) for one month or more?
(If yes, please explain on a separate sheet of paper)
Yes ____ No ____

PERSONAL REFERENCES

Give full name and current address of three peers (with whom you are not professionally associated) who can attest to your current competence. (PEERS MUST BE IN THE SAME SPECIALTY)

1. ______________________________________ Phone/Fax#:__________ _____
2. ______________________________________ Phone/Fax#:__________ _____
3. ______________________________________ Phone/Fax#:__________ _____

MALPRACTICE INSURANCE INFORMATION

Have you ever practiced medicine without professional liability insurance coverage?
If yes, please state years not covered and reason on separate sheet Yes_____ No_____

Have you ever been denied professional liability insurance coverage, in whole or in part, or has your policy every been canceled, 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 of paper. Yes _____ No_____

Have you ever been a defendant in a malpractice/professional liability suit, or have you ever received written notice of intent to file such a suit?
If yes, please complete **Attachment B** Yes _____ No _____

INSURANCE CARRIERS

Please list all insurance carriers, funds, or agencies which presently provide or have provided medical malpractice insurance for you since completion of your residency, including dates of coverage and policy numbers (list the most current year first - attach another sheet if necessary) Please also attach a copy of your current malpractice insurance binder.

Insurance Carrier ______________________________

Policy # ______________________ Dates of Coverage From __________ To __________

Agent Name and Address ______________________________

____

Insurance Carrier ______________________________

Policy # ______________________ Dates of Coverage From __________ To __________

Agent Name and Address ______________________________

____

Insurance Carrier ______________________________

Policy # ______________________ Dates of Coverage From __________ To __________

Agent Name and Address ______________________________

____

Insurance Carrier ______________________________

Policy # ______________________ Dates of Coverage From __________ To __________

Agent Name and Address ______________________________

____

In making application for privileges, I agree to abide by the Medical Staff Bylaws and Rules and Regulations of the hospitals indicated below and by such rules and regulations that may be from time to time enacted and I attest to the fact that I have received a copy of these Bylaws and Rules and Regulations: (check as appropriate)

Memorial Regional Hospital	________
Memorial Hospital West	________
Memorial Hospital Pembroke	________
Joe DiMaggio Children's Hospital	________
Memorial Hospital Miramar	________

In making application, I also agree to abide by the Code of Ethics of the American Medical Association, the American Osteopathic Association, the American Dental Association, the American Podiatry Association, or the American Psychological Association, whichever is applicable and by all applicable laws governing my practice. I agree to provide continuous care for my patients.

I expressly consent to the inspection by the hospital of pertinent records and documents that are material to an evaluation of my professional and ethical qualifications and my ability to carry out the responsibilities associated with the clinical privileges I have requested. I fully understand that any false statements or misrepresentations on this application shall be sufficient grounds to deny or revoke any appointments or privileges which I may seek or obtain at Memorial Regional Hospital, Memorial Hospital West, Memorial Hospital Pembroke, Joe DiMaggio Children's Hospital, and/or Memorial Hospital Miramar.

I agree to update this application while it is being processed should there be any change in the information provided that could affect the application or its outcome.

With my signature, I certify the accuracy of the statements listed in this application and also my physical and mental capabilities to care for my patients in accord with the prevailing professional standard of care at Memorial Regional Hospital, Memorial Hospital West, Memorial Hospital Pembroke, Joe DiMaggio Children's Hospital and/or Memorial Hospital Miramar.

Should I obtain membership on the Medical Staff of Memorial Regional Hospital, Memorial Hospital West, Memorial Hospital Pembroke, Joe DiMaggio Children's Hospital, and/or Memorial Hospital Miramar? I agree to notify the Administrator and/or the Chief of the Medical Staff of any of the following occurrences within the time frame specified:

(1) My license to practice in the State of Florida or any other jurisdiction is under investigation, suspended, surrendered, revoked, terminated or subject to terms of probation or other restrictions or my privileges at any hospital are suspended (excluding any suspension for medical record deficiencies unless the period of such suspension is greater than 60 days), revoked or otherwise terminated - notification due within 72 hours.
(2) I learn that I've become a defendant in any malpractice action or I receive any pleadings, notice or demands of claim, or service of process relating to such a suit, or I am required to pay damages in any such action by way of judgement or settlement - notification within 10 days.
(3) I am indicted or convicted of a felony - notification due within 72 hours.
(4) There is a change in my business address – notification due a minimum of 30 days prior to the effective date of change.
(5) I become incapacitated such that the incapacity may interfere with patient care for twenty-one (21) consecutive days - notification due within 10 days of becoming incapacitated.
(6) Any other act, event, occurrence or the like which materially affects my ability to carry out my duties and obligations as outlined in the Medical Staff Bylaws and Rules and Regulations - notification due within 10 days.
(7) I am under investigation or disciplined by the Department of Professional Regulation, the DEA, or any peer review organization - notification within 10 days.

______________________________ ______________

Signature of Applicant Date

Memorial Healthcare System

Application for Appointment

RELEASE OF LIABILITY FROM APPLICANT

I hereby authorize the Board of Commissioners, Officers of the Medical Staff, Credentials Committee, Department Chiefs, and the Administrators or their designee of Memorial Regional Hospital, Memorial Hospital West, Memorial Hospital Pembroke, Joe DiMaggio Children's Hospital, and/or Memorial Hospital Miramar to contact any references listed by me on my application form for Medical Staff privileges or to contact any other physician, agency, or organization.

I hereby request and authorize any and all agencies, organizations, governmental bodies, corporations, and/or persons including, without limitation, any and all attorneys and/or insurance companies contacted in connection with my application to truthfully answer any and all questions posed by the above-named individuals; to disclose all information concerning my qualifications, education, experience, character, citizenship, and professional background to the fullest extent of their knowledge; and/or to verify or refute any representations or claims which I have made in my application for Medical Staff privileges.

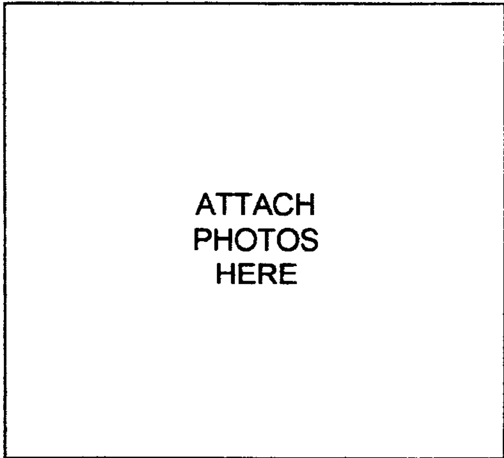
I hereby release and hold harmless from any and all demands, claims, causes of action, and damages arising from or related to any statements, recordings, or writings concerning me, my medical qualifications, and my fitness to practice medicine made by or to any agency, organization, governmental body, corporation, partnership, or joint venture conducting or responding to investigations, evaluations, and inquiries in connection with my application for membership on the Medical Staff of Memorial Regional Hospital, Memorial Hospital West, Memorial Hospital Pembroke, Joe DiMaggio Children's Hospital, and/or Memorial Hospital Miramar.

I agree that a copy of this release shall be sent to those references listed in this application, together with a request for information concerning me and my background, in order that the people writing references may be free to express their honest opinions about my abilities as a practitioner and my reputation as a citizen to the officers and officials of the Memorial Healthcare System who are considering my application for Medical Staff membership.

____
PLEASE PRINT YOUR NAME

____
SIGNATURE

____
DATE



THIS PAGE IS NOT TO BE FILLED IN BY APPLICANT

RECOMMENDATION OF THE DEPARTMENT OF:

____

APPROVED __________ **DENIED** __________

CHIEF ______________________________ DATE ______________

RECOMMENDATION OF THE CREDENTIALS COMMITTEE

APPROVED __________ **DENIED** __________

CHAIRMAN ______________________________ DATE ______________

RECOMMENDATION OF THE EXECUTIVE COMMITTEE

APPROVED __________ **DENIED** __________

SECRETARY ______________________________ DATE ______________

RECOMMENDATION OF THE BOARD OF COMMISSIONERS

APPROVED __________ **DENIED** __________

CHAIRMAN ______________________________ DATE ______________

____ PROVISIONAL MEDICAL STAFF OF MEMORIAL REGIONAL HOSPITAL

____ PROVISIONAL MEDICAL STAFF OF MEMORIAL HOSPITAL WEST

____ PROVISIONAL MEDICAL STAFF OF MEMORIAL HOSPITAL PEMBROKE

____ PROVISIONAL MEDICAL STAFF OF THE JOE DIMAGGIO CHILDREN'S HOSPITAL

____ PROVISIONAL MEDICAL STAFF OF MEMORIAL HOSPITAL MIRAMAR

____ COURTESY MEDICAL STAFF OF ______________________________

____ COURTESY DENTAL STAFF OF ______________________________

____ COURTESY PODIATRY STAFF OF ______________________________

____ AFFILIATE MEDICAL STAFF OF THE JOE DIMAGGIO CHILDREN'S HOSPITAL

ATTACHMENT A

PROCEEDING IDENTIFICATION: ______________________________

Date Proceeding Commenced: ______________ Status (check one): ☐ Pending ☐ Closed

If closed, disposition (check one): ☐ Dismissed ☐ Action Taken

Substance of Allegations ______________________________

____

Substance of Findings ______________________________

____

Additional Information (optional) ______________________________

PROCEEDING IDENTIFICATION: ______________________________

Date Proceeding Commenced: ______________ Status (check one): ☐ Pending ☐ Closed

If closed, disposition (check one): ☐ Dismissed ☐ Action Taken

Substance of Allegations ______________________________

____

Substance of Findings ______________________________

____

Additional Information (optional) ______________________________

ATTACHMENT B

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 Suite Commenced: ____________________ Status (check one): ☐ Pending ☐ Closed

Substance of Allegations: ______________________________

If closed, disposition (check one): ☐ Dismissed ☐ Judgement ☐ 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 Suite Commenced: ____________________ Status (check one): ☐ Pending ☐ Closed

Substance of Allegations: ______________________________

If closed, disposition (check one): ☐ Dismissed ☐ Judgement ☐ Settled

Substance of Findings ______________________________

EMERGENCY MEDICINE
PHYSICIAN PREFERENCE FORM

Print Physician's Name: ____

Physician's Signature: ____

Specialty: ______________________________

PLEASE CHECK ONE OF THE FOLLOWING CHOICES:

- ☐ Please call me whenever any of my patients arrive to the Emergency Department and before the patient leaves the Emergency Department regardless of the need for admission or discharge.

- ☐ I choose to admit all of my patients to the hospital. Please call me **only** for my admissions after the Emergency Department physician has evaluated the patient.

- ☐ I will choose to refer my managed care patients to the appropriate panel physician. Please call the appropriate panel physician for my admissions. **Do not call me for these admissions.**

- ☐ I will always choose to refer my managed care patients to the appropriate panel physician. Please call the appropriate panel physician for my admissions. **Please call me to notify me of the admission, but do not wait for my return call to contact the appropriate panel physician.**

- ☐ I choose to refer all my admitted patients to the following physician. Please call him/her for all of my hospital admissions.

Designated physician's name: ______________________
(please print)

There are many instances when the answering services do not answer, the office lines are constantly busy, or there is an inordinate delay in calling back for whatever reason. We are establishing a "For Emergency Department Eyes Only" database of phone numbers. We will include only those numbers each attending is willing to provide.

Office Number: ________________________

Beeper Number: ________________________

Home Number: ________________________

Cellular Phone: ________________________

E-Mail Address: ________________________

MEDICARE ACKNOWLEDGEMENT STATEMENT

NOTICE TO PHYSICIANS

"Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical records. Anyone who misrepresents, falsifies, or conceals funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

I, ____, the undersigned,
(Print or type full name)

acknowledge having received the above notice.

_______________________________________ ____________________
Legal Signature Date

(Legal signature means that which you would normally use on documents such as wills, checks, etc. Initials are not acceptable).

UPIN __________

- ☐ MRH
- ☐ JDCH
- ☐ MHW
- ☐ MHP
- ☐ MHM

3501 Johnson Street
Hollywood, Florida 33021
(954) 987-2000

South Broward Hospital District

National Provider Identifier

The Centers for Medicare and Medicaid Services have issued the following announcement:

- **WHO?** - All individuals and organizations who meet the definition of a healthcare provider as described at 45 CFR 160.103 are eligible to obtain a National Provider Identifier, or NPI. If you are a HIPAA covered provider or if you are a health care provider who bills Medicare for your services, you need an NPI.
- **WHAT?** - The NPI is a 10-digit number that will be used to identify you to your healthcare partners, including all payers, in all HIPAA standard transactions. The NPI will replace the identifiers you currently use in HIPAA standard transactions that you conduct with Medicare and with other health plans. You will need an NPI prior to enrolling with Medicare.
- **WHEN?** - The NPI compliance date is May 23, 2007. However, CMS recommends that you obtain your NPI at least six months prior to this date to provide you with ample time to test your NPI and share it with all of your health care partners, including payers, clearinghouses, vendors, and other providers.
- **WHY?** - The NPI is an Administrative Simplification mandate of HIPAA.
- **HOW?** – There are three ways that you can obtain your NPI. You can:
  - Complete the on-line application at the NPPES web site (https://NPPES.cms.hhs.gov/NPPES/Welcome.do
  - Download the paper application form at www.cms.hhs.gov/NationalProidentstand/ and mail it to the address on the form; or
  - Authorize an employer or other trusted organization to obtain an NPI for you through bulk enumeration or Electronic File Interchange

- **MORE – go to http://www.cms.hhs.gov/NationalProvIdentStand/ to find additional NPI information**

If you've already received your NPI, please provide it to Memorial Healthcare System's Department of Medical Affairs. Please fax this form to 954-965-6468 or include it with your application.

Name ____________________________

My NPI # is ______________________