

12. Current Position or Scientific Activities:

13. Professional Liability: It is the responsibility of the applicant to request from his/her insurance carrier(s) evidence of the following information be forwarded to the Medical Staff Administration Office:

a. List professional liability carriers below (current and preceding five years):

Period of Coverage	Carrier	Amount of Coverage	Reason for Cancellation
_____	_____	_____	_____
_____	_____	_____	_____

b. Have you been the subject of a malpractice claim or a defendant in a malpractice suit in the past five (5) years? *(If yes, provide a detailed, written explanation on a continuation page.)* Yes No

c. Are there any restrictions or limitations on your current malpractice coverage? *(If yes, provide a detailed, written explanation on a continuation page.)* Yes No

d. Have you maintained continuous malpractice coverage since first obtaining coverage? *(If no, please explain on continuation page)* Yes No

14. Medical References: Names and addresses of four (4) physicians who have worked extensively with you or have been responsible for professional observation of you. Do not list: relatives by blood or marriage; The Chief of Service to which you are applying; persons in current training program with you; nor persons who cannot attest to your current level of clinical competency, technical skill, and medical knowledge.

Name	Mailing Address	Day-time Telephone
① _____	_____	_____
		fax: _____

② _____	_____	_____
		fax: _____

③ _____	_____	_____
		fax: _____

④ _____	_____	_____
		fax: _____

Applicant's Name [printed] _____

15. Professional Sanctions

Any affirmative response requires an explanation. Please attach a written explanation to provide detailed information.

Have any of the following ever been, or are currently in process, either on a voluntary or involuntary basis: denied, revoked, suspended, reduced, limited, placed on probation, not renewed or relinquished for disciplinary reasons?

- a. Medical / Professional license in any state or jurisdiction? Yes No
- b. Participation in any training program? Yes No
- c. ECFMG certification? Yes No
- d. State Controlled Substance Registration? Yes No
- e. Federal DEA Registration? Yes No
- f. Membership on any hospital/medical staff? Yes No
- g. Clinical privileges? Yes No
- h. Participation in the Medicare/Medicaid program? Yes No
- i. Other healthcare organizations (Surgicenter, managed care, PPO, PHO, MSO, etc.)? Yes No
- j. Professional society membership? Yes No
- k. Specialty board certification? Yes No

Additional Information:

- l. Are there any disciplinary actions pending against you? Yes No
- m. Have you ever been convicted of, or pleaded guilty or nolo contendere, to any crime (other than traffic violations)? Yes No
- n. Has any action ever been reported to the National Practitioner Data Bank (NPDB), in which you were named? Yes No

16. Are you currently suffering from, or receiving treatment for, any physical or mental disability or illness, including drug or alcohol abuse, which would impair the proper performance of your essential functions [duties] and responsibilities as a health care provider? Yes No

If yes, use a continuation page to explain any need for accommodations that would enable you to properly perform your essential functions and responsibilities as a health care provider.

17. Date of last physical examination:

Applicant s Name [printed] _____

Continuation Page: Use this page to document additional information. Copy as necessary.

Applicant's Name [printed] _____

Statement of Applicant:

-- I fully understand that any significant misstatements in, or omissions from, this application may constitute cause for denial of appointment to or summary dismissal from, the Hospital Medical Staff and/or The Johns Hopkins University.

-- All information submitted by me in this application is true to the best of my knowledge and belief.

-- I authorize the Hospital and/or the University and their representatives to consult with other hospitals and institutions and their representatives and others, including malpractice carriers, in regard to this application.

-- The Hospital and/or University are further authorized to obtain any information necessary to compile a complete liability insurance claims history.

-- I release from liability the Hospital and/or University, their representatives and agents for their actions or omissions performed in good faith and without malice in evaluating the application as well as those who provide information to the Hospital and/or University in good faith and without malice, and I consent to the release of such information, including otherwise privileged or confidential information.

-- I consent to the release of information to other hospitals and institutions and persons with a legitimate interest and agree to hold the Hospital and/or the University, their representatives and agents free of liability for their actions performed in good faith as a part of the quality assurance program, the credentialing process, peer review and medical evaluation activities.

-- I understand that the information required herein is continuing in nature and I agree to provide any changes in the information provided; i.e., address, name, certification and dates, licensure, etc. I agree to furnish, upon request, an update on any information provided in this application.

-- I agree that, upon the request of any board or committee responsible for review of this training appointment, I shall undergo a complete physical and/or mental health evaluation (concerning my ability to care for patients and/or my ability to work cooperatively with colleagues and support staff) by a physician who is mutually acceptable to me and the board or committee requesting evaluation, and shall agree to make the report of the evaluation a part of the application.

A copy of the Statement of Applicant may be used as original.

Date _____

Signature _____

Printed Name _____

The Johns Hopkins Institutions do not discriminate on the basis of race, color, sex, religion, age, national or ethnic origin, sexual orientation, handicap, veteran status, or any other occupationally irrelevant criteria.

Distribution:

Original: JH Medical Staff Administration
Copies: Department file
JHU Postdoctoral Office

General Instructions

The information on this supplemental application is used for hospital credentialing. All applicants accepted for a clinical appointment, including those who have applied through the ERAS Or other Match Program, must complete this supplement.

Each section must be **complete** and **legible** or your application will be deemed incomplete and returned to you. This pertains to any attachment you include with the application; e.g., CV, copies of licenses, certifications, etc.

- ▶ The verification process on your education, training, and experience will not begin until a completed application has been received.
- ▶ Do not refer to an enclosed curriculum vitae in lieu of completing a section. A CV does not usually contain all the information needed (e.g., complete dates, addresses, names, etc).
- ▶ If a section does not apply to you, write in N/A. Do not leave any block blank.

All chronology must be accounted for from the completion of your medical/professional degree to the present. Gaps of one month or more will cause the verification process to be delayed until you provide an explanation. Delays can also be caused by incomplete names and addresses -- please provide complete information in all sections.

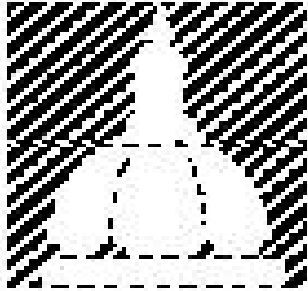
If additional space is needed, attach additional pages (make reference to the question being answered) or, copy the blank application page as often as necessary to provide complete information. Keep these additional pages in sequence with corresponding application pages.

Completion of the Verification Process can take 2 - 3 months. It takes at least three weeks to receive responses to our queries. When the verification process has been completed, your file will be submitted to the department(s) to which you have applied.

If responses to queries are not received within specified time frames, you will be notified and it will be your responsibility to facilitate receipt of the responses. If any questions or concerns arise during the verification process, you will be contacted directly.

The completed supplemental application should be returned to:

Medical Staff Administration
Billings Administration Building, Suite 324
600 North Wolfe Street
Baltimore MD 21287-1824



Johns Hopkins Medicine

**Supplemental Application
for
Residency / Clinical
Fellowship Training Program**

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Match Program, must complete this supplement.