



Name _____
Specialty _____

STATE OF MARYLAND
DHMH

MARYLAND HOSPITAL CREDENTIALING APPLICATION

*Please type or print.
Incomplete or illegible applications will not be processed.*

I. PERSONAL INFORMATION

Name (Last, First, Middle) _____

List any other names used _____

When was name changed? _____ For what reason? _____

SS# _____ Date of birth (MM/DD/YYYY) _____

Place of birth: City _____ State _____ Country _____

Gender M F U.S. Citizen? Yes No

If not, immigration status & Visa number _____

Country of Citizenship _____

Languages spoken other than English _____

Professional degree(s) _____

Home street address _____

City _____ State _____ Zip _____

Home phone number _____ Cell phone _____

Beeper _____ E-mail _____

Work phone number, answering service, or number where you can be reached _____

Preferred mailing address (check one): Home Primary office Office 2

Name _____
Specialty _____

II. CURRENT OFFICE INFORMATION

Copy this page as often as necessary to provide information on all office locations for this appointment.

PRIMARY OFFICE

Group or practice name _____

Street address _____

City _____ State _____ Zip code _____

Office phone(s) _____

Office E-mail _____ Office fax _____

Billing address _____

City _____ State _____ Zip code _____

Fed Tax ID# _____ Dates at this practice: From (MM/YYYY) _____ To: Present

Please complete if you have additional offices.

OFFICE 2

Group or practice name _____

Street address _____

City _____ State _____ Zip code _____

Office phone(s) _____

Office E-mail _____ Office fax _____

Billing address _____

City _____ State _____ Zip code _____

Fed Tax ID# _____ Dates at this practice: From (MM/YYYY) _____ To: Present

OFFICE 3

Group or practice name _____

Street address _____

City _____ State _____ Zip code _____

Office phone(s) _____

Office E-mail _____ Office fax _____

Billing address _____

City _____ State _____ Zip code _____

Fed Tax ID# _____ Dates at this practice: From (MM/YYYY) _____ To: Present

Name _____
Specialty _____

III. EDUCATION AND TRAINING

Please copy this page as needed to provide a complete record of all education and training.

A. PROFESSIONAL AND/OR MEDICAL EDUCATION

School name (if changed, list current name as well as name when you attended)

Degree awarded _____ Date(MM/YYYY) _____ Program type _____

Complete mailing address _____

City _____ State/Country _____

Zip/Postal Code _____ Dates attended: (MM/YYYY) From _____ to _____

School name (if changed, list current name as well as name when you attended)

Degree awarded _____ Date(MM/YYYY) _____ Program type _____

Complete mailing address _____

City _____ State/Country _____

Zip/Postal Code _____ Dates attended: (MM/YYYY) From _____ to _____

Are you ECFMG certified? Yes No Number _____ Date _____

B. GRADUATE OR POST GRADUATE TRAINING

Institution name (if changed, list current name as well as name when you attended)

Specialty _____

Program type (Specify):

Internship Residency Fellowship Specialty Training

Professional program Clinical Research Other:

Complete mailing address _____

City _____ State/Country _____

Zip/Postal Code _____ Dates attended: (MM/YYYY) From _____ to _____

Program director name & title _____

Phone no. _____ Fax _____ E-mail _____

If you did not complete any program, please provide full details on a separate sheet of paper.

Name _____
Specialty _____

Institution name (if changed, list current name as well as name when you attended)

Specialty _____

Program type (Specify):

- Internship Residency Fellowship Specialty Training
 Professional program Clinical Research Other:

Complete mailing address _____

City _____ State/Country _____

Zip/Postal Code _____ Dates attended: (MM/YYYY) From _____ to _____

Program director name & title _____

Phone no. _____ Fax _____ E-mail _____

Institution name (if changed, list current name as well as name when you attended)

Specialty _____

Program type (Specify):

- Internship Residency Fellowship Specialty Training
 Professional program Clinical Research Other:

Complete mailing address _____

City _____ State/Country _____

Zip/Postal Code _____ Dates attended: (MM/YYYY) From _____ to _____

Program director name & title _____

Phone no. _____ Fax _____ E-mail _____

C. OTHER PROFESSIONAL PROGRAM

Institution name (if changed, list current name as well as name when you attended)

Specialty _____

Program type (Specify):

- Internship Residency Fellowship Specialty Training
 Professional program Clinical Research Other:

Complete mailing address _____

City _____ State/Country _____

Zip/Postal Code _____ Dates attended: (MM/YYYY) From _____ to _____

Program director name & title _____

Phone no. _____ Fax _____ E-mail _____

If you did not complete any program, please provide full details on a separate sheet of paper.

Name _____
Specialty _____

IV. AFFILIATIONS AND EMPLOYMENT

- ACCOUNT FOR ALL TIME PERIODS, IN CHRONOLOGICAL ORDER, SINCE COMPLETION OF YOUR PROFESSIONAL EDUCATION.
- ATTACHING A RÉSUMÉ OR CV IS NOT A SUBSTITUTE FOR COMPLETING THIS SECTION.
- PLEASE COPY THIS PAGE AS NECESSARY FOR ADDITIONAL ENTRIES.

Dates: (MM/YYYY) From _____ To _____
Organization name (if changed, list current name as well as former name) _____

Complete address _____

City _____ State/Country _____

Zip/Postal Code _____

Staff category or status of privileges _____ Department _____

Department chair/contact person name & title _____

Phone _____ Fax _____ E-mail _____

Description of duties _____

Reason for leaving _____
.....

Dates: (MM/YYYY) From _____ To _____
Organization name (if changed, list current name as well as former name) _____

Complete address _____

City _____ State/Country _____

Zip/Postal Code _____

Staff category or status of privileges _____ Department _____

Department chair/contact person name & title _____

Phone _____ Fax _____ E-mail _____

Description of duties _____

Reason for leaving _____
.....

Dates: (MM/YYYY) From _____ To _____
Organization name (if changed, list current name as well as former name) _____

Complete address _____

City _____ State/Country _____

Zip/Postal Code _____

Staff category or status of privileges _____ Department _____

Department chair/contact person name & title _____

Phone _____ Fax _____ E-mail _____

Description of duties _____

Reason for leaving _____

EXPLAIN ANY GAPS OF ONE MONTH OR MORE ON A SEPARATE SHEET OF PAPER

Name _____
 Specialty _____

V. PROFESSIONAL LICENSURE/ REGISTRATIONS/ CERTIFICATIONS

List all professional licenses ever held

Licensure/ Registrations/ Certifications	Type	✓ here if N/A	Number	Expiration Date
Maryland Professional License				
Additional Professional License				
<i>Name of State/Country</i>				
Additional Professional License				
<i>Name of State/Country</i>				
Additional Professional License				
<i>Name of State/Country</i>				
Other				
<i>Name of State/Country</i>				
Other				
<i>Name of State/Country</i>				
Other				
<i>Name of State/Country</i>				
Federal DEA				
Maryland CDS				
CPR BLS				
ACLS				
PALS				
Instructor				
Medicaid Provider No.				
Medicare Provider No.				
NPI Number (Indicate if Pending)				
UPIN Number				

Attach a copy of each document you maintain.

VI. U.S. MILITARY SERVICE *N/A*

Dates: (MM/YYYY) From _____ To _____

Current status: _____

Highest rank: _____

Branch: _____

Name _____
 Specialty _____

VII. SPECIALTY/BOARD CERTIFICATION STATUS *N/A*

Specialty/subspecialty in which you are certified or recertified:	Year Certified	Year Recertified	Expiration Date

- A. If you are not certified: YES NO
1. Do you intend to apply (or have you applied) for the certification exam?
 2. Have you ever taken the certification exam?
 3. Number of times you have taken the exam _____
 4. Date your eligibility to take the examination expires/expired _____
- Please explain any "NO" answers to A: _____

- B. Have you been accepted to take the certification examination?
- If "YES," what date are you scheduled to take the exam? _____
- (Please attach a copy of the letter from the Board indicating scheduled dates and/or your status in the process)

C. Please explain why certification does not apply to you: _____

VIII. PROFESSIONAL LIABILITY INSURANCE

- A. Are you presently covered by professional liability insurance? YES NO
- B. Have you been continuously covered since first obtaining professional liability insurance?
- Please explain any "NO" answers to questions A & B:*

- C. Are there any restrictions, limitations, or exclusions to your current professional liability coverage?
- D. Has your professional liability coverage (past or present) ever been denied, limited, reduced, interrupted, terminated, or not renewed by action of the insurance company?
- Please explain any "YES" answers to questions C & D:*

- E. Have you ever been, or are you currently, the subject of a professional liability suit, including malpractice claims?
- F. Have any judgments or settlements ever been paid on your behalf?
- Please explain any "YES" answers to questions E & F on page 9*

Name _____
 Specialty _____

G. PROFESSIONAL LIABILITY CARRIER(S):

- PLEASE PROVIDE THE FOLLOWING INFORMATION FOR EACH PROFESSIONAL LIABILITY CARRIER YOU HAVE HAD IN THE PAST FIVE YEARS.
- INCLUDE ANY COVERAGE MAINTAINED DURING TRAINING PROGRAMS IF WITHIN THE PAST FIVE YEARS. IF MORE SPACE IS REQUIRED, PLEASE COPY THIS PAGE.
- PLEASE EXPLAIN ANY GAPS OR PERIODS WHEN YOU WERE WITHOUT PROFESSIONAL LIABILITY COVERAGE ON A SEPARATE SHEET OF PAPER.

Provide a legible, clear copy of the face sheet from your current professional liability coverage.

Current Carrier:	Name:
	Full Address
	City State Zip
Policy Number:	Phone Number
Period of coverage:	From: To:
Limits of coverage:	
Type of coverage:	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Extended Reporting Policy (Tail)

Previous Carrier:	Name:
	Full Address
	City State Zip
Policy Number:	Phone number
Period of coverage:	From: To:
Limits of coverage:	
Type of coverage:	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Extended Reporting Policy (Tail)
Reason for discontinuance:	

Previous Carrier:	Name:
	Full Address
	City State Zip
Policy Number:	Phone number
Period of coverage:	From: To:
Limits of coverage:	
Type of coverage:	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Extended Reporting Policy (Tail)
Reason for discontinuance:	

Previous Carrier:	Name:
	Full Address
	City State Zip
Policy Number:	Phone Number
Period of coverage:	From: To:
Limits of coverage:	
Type of coverage:	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Extended Reporting Policy (Tail)
Reason for discontinuance:	

Name _____
Specialty _____

H. CLAIMS HISTORY: N/A

- COMPLETE THE FOLLOWING INFORMATION AS IT PERTAINS TO YOUR PROFESSIONAL LIABILITY AND CLAIMS HISTORY.
- PROVIDE INFORMATION ON ANY AND ALL PROFESSIONAL LIABILITY SUITS IN WHICH YOU WERE NAMED, REGARDLESS OF THE OUTCOME.
- IF MORE SPACE IS REQUIRED, PLEASE COPY THIS PAGE BEFORE COMPLETING.

Date of alleged incident _____

Plaintiff(s) _____ Patient's Name _____

State/Country in which suit was initiated _____ Date _____

Health Claims Arbitration or Court case number _____

Insurance carrier and address _____

You were: Primary defendant Co-defendant

Description of allegation or complaint:

Your professional relationship with patient: Attending Consultant Resident
 Other _____

Describe your clinical care in this case:

Current status of suit:
 Filed Deposed Settled in favor of: Plaintiff
 Settled out of court Awaiting trial Defendant
 Dismissed or withdrawn Other: please describe _____

Date of resolution: _____ Amount of settlement (if applicable) _____

IX. ADDITIONAL QUESTIONS

All affirmative answers must be fully explained on a separate sheet of paper.

A. PROFESSIONAL DISCIPLINARY ACTIONS:

YES NO

1. Have any of the following ever been, or are in the process of being, voluntarily or involuntarily withdrawn, relinquished, not renewed, reduced, limited, placed on probation, denied, revoked, suspended, or investigated:
 - a. Any professional license in any state or jurisdiction YES NO
 - b. Any other professional registration or license YES NO
 - c. DEA/CDS Registration YES NO
 - d. Academic appointment YES NO
 - e. Membership on the staff of any facility, health plan, or HMO YES NO
 - f. Clinical privileges/rights on the staff of any facility, health plan, or HMO YES NO
 - g. Board certification YES NO
 - h. Medicare or Medicaid participation YES NO
 - i. Internship or residency program YES NO
 - j. Any research activities YES NO
 - k. Any other type of professional sanction (i.e., Quality Improvement Organization, CLIA, OSHA, etc.) YES NO
2. Have you ever resigned in order to avoid revocation, suspension, or reduction of privileges at any facility or institution? YES NO
3. Has information pertaining to you ever been reported to the National Practitioner Data Bank? YES NO
4. Have you ever been sanctioned or otherwise disciplined by a professional organization and/or licensing board for a violation of ethical standards? YES NO

B. HEALTH STATUS NOTE: JCAHO REQUIRES CONFIRMATION OF THE APPLICANT'S HEALTH STATUS

1. Do you have, or have you ever had, any physical or mental condition (including drug or alcohol abuse) that currently limits or adversely affects your ability to fully participate in the care of your patients? YES NO
2. Have you ever been hospitalized, institutionalized, or involved in a treatment program that currently limits your ability to fully participate in the care of your patients? YES NO
 1&2: If such an impairment exists, please provide a description (on a separate sheet of paper) to include associated limitations and any accommodation(s) that would enable you to perform your duties consistent with accepted standards of practice.
3. Have you ever been sanctioned, reprimanded or otherwise disciplined in any manner by any state licensing authority or other professional board or peer committee for conduct related to the use of alcohol or the use of drugs? YES NO
4. Are you engaged in the illegal use of drugs? YES NO

C. OTHER

1. Have you ever been named a defendant in any criminal case, other than misdemeanor traffic violation? YES NO
2. Have you ever pled guilty, nolo contendere, been convicted of, received probation before judgment, or other diversionary disposition for driving while impaired, or for a controlled dangerous substance offense? YES NO
3. Have you ever been disciplined or counseled for engaging in harassment or discrimination on the basis of race, creed, religion, gender, or sexual orientation? YES NO
4. Have you ever been the subject of an administrative, civil, or criminal complaint or investigation regarding sexual misconduct or child abuse? YES NO
5. Do you, alone or jointly, have ownership in any medical facility, medical services, or equipment to which you might refer patients? YES NO

Name _____
Specialty _____

X. CONTINUING EDUCATION

The hospital to which you are applying may require detailed information regarding this section. Refer to the hospital-specific instructions that came with this application.

Have you met the CEU/CME requirements for maintaining your professional license?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
Have you participated in CEUs/CMEs pertinent to your specialty?	<input type="checkbox"/>	<input type="checkbox"/>

If "NO" to either of above, please explain:

XI. PROFESSIONAL REFERENCES

Each hospital has its own requirements for this section. Refer to the hospital-specific instructions that came with this application. Please note: JCAHO requires peer references for all physicians.

Name: _____
Title: _____ Relationship: _____
Mailing address: _____
City: _____ State/Country: _____ Zip/Postal Code: _____
Phone: _____ Fax: _____ E-mail: _____

Name: _____
Title: _____ Relationship: _____
Mailing address: _____
City: _____ State/Country: _____ Zip/Postal Code: _____
Phone: _____ Fax: _____ E-mail: _____

Name: _____
Title: _____ Relationship: _____
Mailing address: _____
City: _____ State/Country: _____ Zip/Postal Code: _____
Phone: _____ Fax: _____ E-mail: _____

Name: _____
Title: _____ Relationship: _____
Mailing address: _____
City: _____ State/Country: _____ Zip/Postal Code: _____
Phone: _____ Fax: _____ E-mail: _____

Name _____
Specialty _____

XII. AFFIRMATION

I hereby attest and affirm that the information contained in this application is current, correct, and complete to the best of my knowledge. I affirm that I have read the hospital bylaws and rules and regulations of the medical staff and I agree to abide by those guidelines as they presently exist or as periodically amended. I understand that willful falsification or omission of information will be grounds for rejection or termination. I understand that this application is not complete unless a signed hospital-specific attestation is attached.

Name (Print) _____

Signature _____

Date: _____

Note: Sign and date this page within 10 days of submitting application.

XIII. STATISTICAL INFORMATION

The following information is supplied voluntarily and will be used only for statistical and governmental reporting requirements. Information contained in this section will not be used during consideration of the application.

ETHNICITY/RACE:
(Self-identification)

ETHNICITY:

- Of Hispanic or Latino origin Not of Hispanic or Latino origin
A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Race:

Please Note: Multiracial candidates may select all applicable racial categories.

- | | |
|--|---|
| <input type="checkbox"/> American Indian or Alaskan native:
<i>A person having origins in any of the original peoples of North, Central, or South America who maintains tribal affiliation or community attachment.</i> | <input type="checkbox"/> Native Hawaiian or other Pacific Islander:
<i>A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands</i> |
| <input type="checkbox"/> Asian:
<i>A person having origins in the Far East, Southeast Asia or the Indian sub-continent.</i> | <input type="checkbox"/> White:
<i>A person having origins in any of the original peoples of Europe, North Africa, or the Middle East</i> |
| <input type="checkbox"/> Black or African American:
<i>A person having origins in any of the original groups of Africa.</i> | |