

# *University of Maryland Medical Center*



## *Maryland State Hospital Credentialing Application & UMMS Medical Staff Membership Addendum*

**Facilities Credentialed by this office:  
University of Maryland Medical Center  
University Specialty Hospital**

Please return your application via 1<sup>st</sup> class postal service. If you received this application via Airborne Express, all documents should be returned in the enclosed prepaid overnight envelope. Call Airborne pick up service at 1-800-AIRBORNE (247-2676)

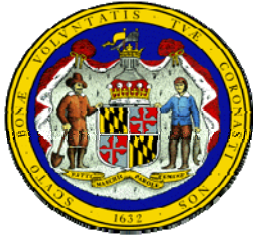
**University of Maryland Medical System  
Medical Staff Services  
110 South Paca Street, 8<sup>th</sup> Floor (Please note our new address)  
Baltimore, MD 21201  
Telephone: (410) 328-2902  
Fax: (410) 328-6433  
Website: [www.umm.edu/med\\_staff\\_services](http://www.umm.edu/med_staff_services)**

Name \_\_\_\_\_  
Specialty \_\_\_\_\_

## **MEDICAL STAFF APPLICATION INSTRUCTIONS**

Please read the following instructions carefully, as proper completion and submission of your application is essential for consideration of your appointment.

1. Please complete BOTH the Maryland Hospital Credentialing Application AND Medical Staff Membership Addendum in full. DO NOT leave any items blank. **DO NOT USE WHITEOUT**. If a response is “no”, “none” or “not applicable”, please state. **If you make a mistake, cross out the error and initial**. Any material misstatements in, or omissions from the application constitutes grounds for denial of appointment or for summary suspension without recourse.
  2. Please type or print all responses.
  3. For all requested addresses, please furnish complete street address, city, state, and zip code. Please include correct telephone, fax numbers and email addresses.
  4. Use additional paper, if necessary, to supply complete responses.
  5. In addition to the completed application and addendum, the following documentation, if applicable, must be returned in order for your application to be processed\*: **PLEASE DO NOT DELAY IN RETURNING YOUR APPLICATION PENDING RECEIPT OF THESE ITEMS.**
    - a) Current Curriculum Vitae noting month/year of all training and hospital affiliations;
    - b) Copy of current Maryland professional license (s); \*
    - c) Copy of Federal Drug Enforcement Administration (DEA) registration; \*/\*\*
    - d) Copy Maryland CDS registration; \*
    - e) Copy of any/all Board Certification (s), where applicable;
    - f) Professional liability insurance certificate issued to the University of Maryland Medical System, Maryland Medicine Comprehensive Insurance Program consent form(enclosed), or proof of coverage provided by the University of MD Dental School.
    - g) Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable.
    - h) Current Federally Issued Identification (Driver’s License or Passport)
    - i) Completion of UMMC Employee Health Pre-Employment physical or evidence of current PPD test results. (within the past year)
  6. Submit a completed Delineation of Privileges/ Approved Written Agreement/ Job Description along with the credentialing application.
  7. Submit a current photo. A standard passport photo is acceptable. The Joint Commission requires the organization verify that the applicant in the photo is the same as the individual in the credentialing material. This photo will not be used during the decision making process, but only to identify the applicant as the individual in the credentialing material.
  8. Submitted application must have an original signature and be dated within 10 days of submitting the application.
  9. All practitioners must comply with the UMMC Pain Management policy, which requires at least one continuing education credit be related to pain and its management. To meet the criteria, the applicant may attend conferences or read 1 article from the approved list located on the Medical Staff Services website. Once you have read one of the approved articles indicate the name in question B, section II of the UMMC Membership Addendum. For additional information, please contact the appropriate Medical Staff Coordinator named in the cover letter.
- \* **Do not delay in returning your appointment packet** if the following items have not been obtained: Maryland state professional licensure, Federal DEA registration, or Maryland state CDS registration or written agreement with the Board of Nursing/Medicine. The applicant may forward said items under separate cover when received. Please complete the page “UMMC Prescribing Status” attestation sheet. If privately insured, your insurance company must forward the Certification of Insurance directly to UMMC Medical Staff Services Department at the address above.
- \*\* If the applicant will be relocating from out of the state of Maryland, the Federal DEA requires the change of professional or business address after relocation. A written report must be sent to the Drug Enforcement Administration, 200 St. Paul Place, Suite 2222, Baltimore, MD 21212. A revised/corrected Federal DEA registration must be received by this office before a practitioner will be allowed to administer/prescribe any controlled substances at the Medical Center/USH.



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
<b>Maryland Professional License</b>				
<b>Additional Professional License</b>				
<i>Name of State/Country</i>				
<b>Additional Professional License</b>				
<i>Name of State/Country</i>				
<b>Additional Professional License</b>				
<i>Name of State/Country</i>				
<b>Other</b>				
<i>Name of State/Country</i>				
<b>Other</b>				
<i>Name of State/Country</i>				
<b>Other</b>				
<i>Name of State/Country</i>				
<b>Federal DEA</b>				
<b>Maryland CDS</b>				
<b>CPR BLS</b>				
<b>ACLS</b>				
<b>PALS</b>				
<b>Instructor</b>				
<b>Medicaid Provider No.</b>				
<b>Medicare Provider No.</b>				
<b>NPI Number (Indicate if Pending)</b>				
<b>UPIN Number</b>				

*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:	



**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   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Any other professional registration or license  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. DEA/CDS Registration  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Academic appointment  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Membership on the staff of any facility, health plan, or HMO  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Clinical privileges/rights on the staff of any facility, health plan, or HMO  | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Board certification   | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Medicare or Medicaid participation  | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Internship or residency program   | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Any research activities   | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Any other type of professional sanction (i.e., Quality Improvement Organization, CLIA, OSHA, etc.)  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever resigned in order to avoid revocation, suspension, or reduction of privileges at any facility or institution?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has information pertaining to you ever been reported to the National Practitioner Data Bank?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been sanctioned or otherwise disciplined by a professional organization and/or licensing board for a violation of ethical standards?  | <input type="checkbox"/> | <input type="checkbox"/> |

**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?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 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?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you engaged in the illegal use of drugs?  | <input type="checkbox"/> | <input type="checkbox"/> |

**C. OTHER**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1. Have you ever been named a defendant in any criminal case, other than misdemeanor traffic violation?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been the subject of an administrative, civil, or criminal complaint or investigation regarding sexual misconduct or child abuse?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you, alone or jointly, have ownership in any medical facility, medical services, or equipment to which you might refer patients?   | <input type="checkbox"/> | <input type="checkbox"/> |



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:<br><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:<br><i>A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands</i> |
| <input type="checkbox"/> Asian:<br><i>A person having origins in the Far East, Southeast Asia or the Indian sub-continent.</i>   | <input type="checkbox"/> White:<br><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:<br><i>A person having origins in any of the original groups of Africa.</i>   |   |



110 South Paca Street, 8<sup>th</sup> Floor  
Baltimore, Maryland 212011  
Phone: (410) 328.2902  
Fax: (410) 328.6433  
www.umm.edu/Med\_staff\_services

Name \_\_\_\_\_  
Specialty \_\_\_\_\_

## University of Maryland Medical System Medical Staff Membership Addendum

### Part I

#### Faculty Appointment Information

UMAB Faculty Title: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Full-Time: \_\_\_\_\_ Part-Time: \_\_\_\_\_ Volunteer: \_\_\_\_\_ (\_\_\_ faculty appointment pending)

Primary Department: \_\_\_\_\_ Division: \_\_\_\_\_

Job Title: \_\_\_\_\_

Secondary Dept: \_\_\_\_\_ Division: \_\_\_\_\_

### Part II

#### Continuing Professional Education

A. Please provide evidence of completing a continuing education offering about pain and its management, in accordance with the hospital's mandatory Pain Management Policy: (see #9 on instruction sheet for more information)

\_\_\_ Read Article(s) please list: \_\_\_\_\_

\_\_\_ Attend Conference(s) please list: \_\_\_\_\_

### Part III

#### Professional Memberships/ Associations

(\_\_\_ N/A)

Please list all professional society memberships/fellowships

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_  
Specialty \_\_\_\_\_

**Part III**

**Professional Liability Coverage**

A. Are you applying for coverage from the Maryland Medicine Comprehensive Insurance Program (UMMS Trust)? (not applicable for Department of Dentistry applicants) \_\_\_\_\_ YES \_\_\_\_\_ NO

\*\*\*NOTE: A Certificate of Insurance issued to the University of Maryland Medical System must accompany this application if you are NOT applying for coverage through MMCIP.\*\*\*

**Please complete Question B & C ONLY if you will be covered by the Maryland Medicine Comprehensive Insurance Program:**

B. List all locations, other than UMMS, where you will be providing patient care, clinical and/or administrative services:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Please indicate what your faculty responsibilities will be:

	YES	NO
Administration	_____	_____
Patient Care (including supervision of residents or students)	_____	_____
Research involving human subjects	_____	_____
Research not involving human subjects	_____	_____
Didactic teaching/other (please specify : _____)	_____	_____

**Part IV**

**UMMS Affiliation(s)**

A. Have you ever applied for privileges at University of Maryland Medical System, University CARE, Kernan Hospital, University Specialty Hospital? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please list facility (ies):

\_\_\_\_\_  
\_\_\_\_\_

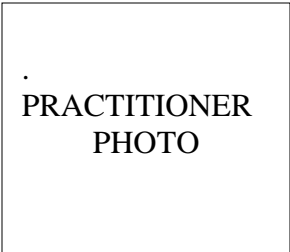
B. Please check all privileges requested:

_____ UMMC Attending	_____ Resident/ Fellow: PGY _____
_____ Kernan Attending	_____ Rotator (Name of Facility _____)
_____ University Specialty Hospital	_____ Allied Health Practitioner ( _____ Type)
_____ University CARE-NETWORK	

**CONDITIONS OF APPOINTMENT AND CONSENT TO RELEASE OF INFORMATION -revised 5/03**

By applying for appointment to the medical staff of the University of Maryland Medical System, I understand and agree to the following:

1. All information submitted by me in this application is correct and complete to my best knowledge and belief. I fully understand that any significant mis-statements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff of the University of Maryland Medical System.
2. I agree that, if appointed, I will read and follow the Medical Staff Bylaws and the Rules and Regulations applicable to the medical staff, as they may be changed from time to time.
3. I authorize the Medical System and its representatives, including members of the medical staff, to consult with other hospitals and their representatives and others, including malpractice carriers, in regard to this application. I understand that requests may be made of past or present medical affiliates, professional societies, licensing bodies, and other agencies regarding criminal history information. I release from liability representatives of the Hospital for their acts and services performed in good faith and without malice in evaluating the application. In addition, I release from liability those who may provide information to the Medical System in good faith and without malice, and I consent to the release of any information which any other person, service, hospital, institution, professional society or licensing body may have which is related to the subject matters inquired of in this application, or to my qualification for medical staff membership.
4. I authorize, without reservation, any government agency contacted by the University of Maryland Medical System and/or any other consumer reporting agency engaged by the Medical System, to furnish information as to whether (a) I am excluded from participation in Medicare, Medicaid and/or any other Federal health care program or (b) if I am suspended, debarred or otherwise excluded from Federal Procurement and Nonprocurement Programs. This authorization includes, but is not limited to, obtaining and using information from the published List of Excluded Individuals/Entities (LEIE) maintained by the Office of the Inspector General (OIG) of the Dept of Health and Human Services (HHS) and the List of Parties Excluded from Federal Procurement and Nonprocurement Programs maintained by the Government Services Administration (GSA).
5. I consent to the release of information by the Medical System and its representatives, including members of the medical staff and the University of Maryland Medical Center Insurance Program, to other hospitals and their representatives, and to others\*, including professional liability insurance carriers representing the Hospital, or persons affiliated with the Medical System, provided that those to whom information is released have a legitimate interest in such information and provided that the information released pursuant to my consent may pertain to my appointment, reappointment, privilege delineation, disciplinary proceedings of any other hospital or health care institution which is related to patient care and professional conduct. I further understand that the information may relate to my professional qualifications, clinical competency, character, mental and emotional stability, ethics, physical condition, ability to work compatibly with my peers and other Medical System personnel, and any other matters that might directly or indirectly have an effect on my ability to render quality patient care.  
  
\*If I am a full-time or part-time member of the faculty of the School of Medicine who will provide billable services through a professional association under the Medical Service Plan, "others" includes third party payors with whom my professional association (and/or University Physicians, Inc. on behalf of my professional association) contracts, for the purpose of enabling these third party payors to accept me as a participating provider.
6. I agree to participate in and cooperate with the Medical System's quality, utilization, and risk management programs. I agree to hold the Medical System and representatives of the Medical System free from liability for actions performed in good faith as part of these programs.
7. I understand that, except for communications noted above in paragraphs 3 and 4, my application and all deliberations relating the consideration of my application shall be regarded and held as privileged and confidential documents by the Medical System and medical staff to the fullest extent permitted by law. This also shall apply to the minutes of any hospital committee or other body which may consider my request for privileges.
8. I understand that I am obligated to report immediately to the Medical System any occurrences, incidents, actions or other information relating to questions in this application, if such occur following the filing of this application or its acceptance.
9. I agree to provide for continuous care for all patients under my care and to perform only that medical and surgical management for which I have requested and have been granted privileges, or which I am permitted by the Medical Staff Bylaws to perform in order to save the life of a patient in an emergency situation. I understand that if any application is rejected, I shall have no privileges whatsoever at the Medical System or only those privileges eventually approved by the Governing Board of the Medical System.
10. I understand that as a member of the Medical Staff, I am participating with the Medical System in an organized health care arrangement as defined by the Privacy Regulations under HIPAA. I agree to comply with Medical System policies on protected health information and its Notice of Information Privacy Practices with regard to Medical System patients.



Applicant's Signature: \_\_\_\_\_  
 Applicant's Name Printed: \_\_\_\_\_  
 Date: \_\_\_\_\_

MARYLAND MEDICINE COMPREHENSIVE INSURANCE PROGRAM  
SELF INSURANCE TRUST

Consent to Release Information

As a condition of consideration of my application for professional liability coverage through the Maryland Medicine Comprehensive Insurance Program Self-Insurance Trust (the TRUST). I hereby authorize the release of information regarding my claims and insurance history and related information to appropriate representative of the TRUST. I further authorize inspection of any records or documents, which may be relevant to an evaluation of my claims and insurance history and related information.

I hereby release from all liability the TRUST, its employees, agents, officers, representatives, attorneys, participating entities, subsidiaries, successors or assign, or any acts connected with evaluation of my claims and insurance history and related information to the fullest extent allowed by law.

I also release from liability all individuals and organizations who provide information to the TRUST concerning my claims and insurance history and related information, including privileged and/or confidential information. I understand that such communications and any deliberations relating to this application shall be privileged and confidential in accordance with applicable law.

If I am granted coverage through the TRUST, I agree to abide by any existing conditions of coverage of the TRUST, and other applicable professional liability insurance policies as they currently exist or as amended from time to time, and otherwise comply fully with the Office of Risk Management and its scheduled programs including attendance of the mandatory Risk Management Orientation within the designated time period.

As a condition of coverage through the TRUST, I must personally report any known occurrence or circumstance which has the potential of becoming a liability claim against myself or the TRUST within 30 days of its occurrence, to the Office of Risk Management (410) 328-4704. Among circumstances to report are:

1. Death (unexpected or unexplained)
2. Paralysis, paraplegia, quadriplegia
3. Spinal cord injury
4. Brain damage
5. Total or partial loss of limb or loss of the use of limb
6. Sensory organ or reproductive organ impairment
7. Disability or disfigurement
8. Any assertion by a patient that he/she has been medically injured
9. Any injury to a part of the anatomy not undergoing treatment
10. Misdiagnosis of patient's condition resulting in increased morbidity
11. Injury/death to either child or mother during delivery
12. Any assertion by the patient or family that consent for treatment (medical or surgical) was not given
13. Any birth when the baby is stillborn, or expires shortly after delivery
14. Nerve or Neurological Deficit

Failure to comply with these specific requirements could jeopardize my coverage and future participation in the Trust.

I further understand that any significant misstatements in, or omissions from, this application, and/or refusal to comply with the conditions of coverage, could cause denial, withdrawal of coverage, or jeopardize my future participation in the TRUST.

I have completed this application truthfully and understand that any decision by the TRUST to provide coverage to me will be based in part on this application. I promise to advise the TRUST immediately of any changes, which would alter my responses on the application. I agree to comply fully with the Conditions of Coverage of the TRUST and the rules, regulations and requirements of the Office of Risk Management, upon acceptance of my application.

Applicant Signature: \_\_\_\_\_

Applicant Printed Name: \_\_\_\_\_

\_\_\_\_\_ Date

