



110 South Paca Street, 8th Floor
Baltimore, MD 21201
Phone: (410) 328-2902
fax: (410) 328-6433

CREDENTIALING APPLICATION
University of Maryland Medical Center
Medical Staff Services Department
110 South Paca Street, 8th Floor
Baltimore, MD 21201

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 this application 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 omission 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 beeper, email and FAX numbers if applicable.
 4. Use additional paper, if necessary, to supply complete responses.
 5. In addition to the completed application, the following documentation, if applicable, must be returned in order for your application to be processed*:
 - a. Current Curriculum Vitae;
 - b. Copy of current Maryland license (if applicable); *
 - c. Copy of Federal Drug Enforcement Administration (DEA) registration (if applicable); */**
 - d. Copy of Maryland CDS registration (if applicable); *
 - e. Copy of Board Certification, if applicable;
 - f. Copy of Educational Commission for Foreign Medical Graduates (ECFMG) Certificate, if applicable.
 - g. For Rotating/Visiting Residents only: Documentation from your home program of your current TB test results (must be within the last year) or negative chest x-ray results.
 6. ***Special Training Participants Only***
Professional liability insurance certificate issued to the University of Maryland Medical System.
 7. Submit a completed Delineation of Privileges/Approved Written Agreement/Job Description form along with the application (as applicable).
 8. Please return your application via 1st class postal service. If you received this application via Airborne Express, all documents should be returned in the enclosed prepaid overnight envelope. Call Airborne at 1-800-247-2676 for pickup.
- * Do not delay returning your appointment packet if you have not received licensure, DEA, or CDS in Maryland. You may forward those items under separate cover when received. If privately insured, your insurance company may forward the Certification of Insurance directly to the UMMS Medical Staff.
- ** If you are coming from out of the State of Maryland, the Federal DEA requires that you report in writing any change of professional or business address. Your written report must be sent to the Drug Enforcement Administration, 200 St. Paul Place, Suite 2222, Baltimore, MD 21212. A revised Federal DEA Registration must be received by this office before you will be allowed to administer any controlled substances.
-

Check which is applicable <input type="checkbox"/> Resident/Fellow <input type="checkbox"/> Special Training

RESIDENT/SPECIAL TRAINING CREDENTIALING APPLICATION

PART I: PERSONAL INFORMATION

Name (Last, First, Middle): _____

Previous name that degree would be under: _____

Degree (MD, DDS, RN, etc.): _____ Gender: Male Female

Date of Birth: _____ Social Security Number: _____

Place of Birth: City _____ State _____ Country _____

Citizenship: USA by Birth Other(specify) _____ Naturalized US Citizen

Department: _____ Subspecialty: _____

Primary Office Address: _____

Office Phone: _____ Office Fax: _____

Office e-mail: _____

Home Address: _____

Home Phone: _____ Beeper: _____

Home e-mail: _____

Preferred Mailing Address: Office Home

PART II: EDUCATION

1. Undergraduate (School name & complete address)

School Name _____

Degree Awarded _____ Program Title _____

Mailing Address _____

Dates Attended (MM/YY) From _____ to _____

2. Medical/Dental School (name & complete address)

School Name _____

Degree Awarded _____ Program Title _____

Mailing Address _____

Dates Attended (MM/YY) From _____ to _____

3. Other Graduate Education (Institution and complete address)

School Name _____

Degree Awarded _____ Program Title _____

Mailing Address _____

Dates Attended (MM/YY) From _____ to _____

4. If you are a foreign medical graduate, please complete the following: (NOT APPLICABLE _____) Please attach copy.

ECFMG Number: _____ Date Passed: _____ Valid Until: _____

5. Graduate or Post Graduate Training (Please account for all time periods following medical/dental school/ professional school graduation)

a. **Institution** _____

Program type (Specify):

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

Specialty _____ Dates Attended (MM/YY) From _____ to _____

Mailing Address _____

Program Director _____

Phone/Fax/Email _____

Program Completed? Yes No (If no, please provide explanation on page 11)

b. **Institution** _____

Program type (Specify):

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

Specialty _____ Dates Attended (MM/YY) From _____ to _____

Mailing Address _____

Program Director _____

Phone/Fax/Email _____

Program Completed? Yes No (If no, please provide explanation on page 11)

c. **Institution** _____

Program type (Specify):

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

Specialty _____ Dates Attended (MM/YY) From _____ to _____

Mailing Address _____

Program Director _____

Phone/Fax/Email _____

Program Completed? Yes No (If no, please provide explanation on page 11)

d. **Institution** _____

Program type (Specify):

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

Specialty _____ Dates Attended (MM/YY) From _____ to _____

Mailing Address _____

Program Director _____

Phone/Fax/Email _____

Program Completed? Yes No (If no, please provide explanation on page 11)

Name: _____

Date: _____

PART III: PROFESSIONAL CAREER (Please account for all time periods following medical/dental/professional school graduation)

1. Hospital/Health Care Facilities Affiliations: List all present and prior affiliations. (NOT APPLICABLE _____)

- a. Facility Name _____
 Street Address _____
 City/State/Zip _____
 Staff Category _____ Status of Privileges _____
 Department/Service _____ Dates of Affiliation: From _____ to _____
 Supervisor's Name _____ Phone/Fax/Email _____

- b. Facility Name _____
 Street Address _____
 City/State/Zip _____
 Staff Category _____ Status of Privileges _____
 Department/Service _____ Dates of Affiliation: From _____ to _____
 Supervisor's Name _____ Phone/Fax/Email _____

- c. Facility Name _____
 Street Address _____
 City/State/Zip _____
 Staff Category _____ Status of Privileges _____
 Department/Service _____ Dates of Affiliation: From _____ to _____
 Supervisor's Name _____ Phone/Fax/Email _____

2. Military Duty (NOT APPLICABLE _____)

<u>Date From</u>	<u>Date To</u>	<u>Serial or Svc #</u>	<u>Branch of Service</u>	<u>Type of Discharge*</u>
_____	_____	_____	_____	_____

*Explain on another sheet of paper if discharge was not honorable

3. In the time since you began your professional career (post medical/professional school), have there been any gaps or periods in which you were not employed in medical practice? (more than three months)
 ____ Yes ____ No (If yes, please provide an explanation below)

PART IV: MEDICAL/DENTAL BOARD EXAMINATIONS (Please indicate examinations passed): (NOT APPLICABLE _____)

NBME	Part I _____ Date	Part II _____ Date	Part III _____ Date
NBDE	Part I _____ Date	Part II _____ Date	
USMLE	Part I _____ Date	Part II _____ Date	Part III _____ Date
FLEX	_____ Date		
NBOME	Part I _____ Date	Part II _____ Date	Part III _____ Date

Name: _____

Date: _____

PART V: LICENSES/REGISTRATIONS (ALL CURRENT AND PRIOR) (Please attach copies of all current licenses to application)

1. Current Maryland Medical License Number: _____ Expiration Date: _____

OR

Unlicensed Medical Practitioner (UMP) Registration Number (if currently/previously enrolled in Maryland residency/fellowship) _____

2. Other Professional Licenses Held: Please list all professional licenses ever held (including Medical/Dental Licenses)

Type of License	State	Number	From	To

3. Have you met continuing medical education requirements for licensure by all state Boards which you are licensed?
___ Yes ___ No ___ N/A (**explanation required if answered "No"**)

4. Drug Control (Controlled Substance) Registration: (NOT APPLICABLE _____) (**Please attach copies to application**)

Federal (DEA) Number: _____ Expiration Date: _____
*must have Maryland address to be used in Maryland

State (CDS) Number: _____ Expiration Date: _____

5. NPI Number: _____ or Check if NPI applied for: _____

PART VI: BOARD CERTIFICATION AND PROFESSIONAL MEMBERSHIPS

1. Board Certification Status <u>Board Name</u>	Date <u>Certified</u>	Date <u>Recertified</u>	If Not Certified, <u>Eligible Until:</u>
_____	_____	_____	_____
_____	_____	_____	_____

If not eligible for certification, please explain: _____

PART VII: PROFESSIONAL LIABILITY COVERAGE

1. Are you presently covered by professional liability insurance? ___ Yes ___ No

Current Carrier:	Name:
	Full Address
	City State Zip
Policy 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)

3. Please list all previous professional liability carriers:*

Previous Carrier:	Name:
	Full Address
	City State Zip
Policy 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:	
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)

*use additional sheet of paper if necessary

Please explain any gaps or periods when you were without malpractice coverage:

3. Malpractice History:

	YES	NO
a. Are any liability claims pending/under investigation against you?	___	___
b. Has any judgment been entered against you in any professional liability case?	___	___
c. Has any settlement been made in any professional liability case in which you or your insurance carrier had to or agreed to make monetary payment?	___	___
d. Have any professional liability claims been filed against you or have you reported any malpractice claim to any insurance carrier?	___	___
e. Have you been notified or are you aware that a claim may be made against you?	___	___
f. Have you been denied professional liability insurance?	___	___
g. Has any professional liability insurer refused to renew your policy or placed limitations on the scope of your coverage?	___	___

If any answer to questions 3a - 3e is yes, please provide full information on the Malpractice Claims/Suit History Addendum (page 10)
 If any answer to 3f or 3g is yes, please provide full information on page 11

PART VIII: VOLUNTARY, INVOLUNTARY, AND/OR PROFESSIONAL DISCIPLINARY ACTIONS:

Either voluntarily or involuntarily, have any of the following ever been, or are currently being: withdrawn, relinquished, not renewed, reduced, limited, placed on probation, denied, revoked, suspended, or currently pending/under investigation: (If "Yes", please provide a full explanation on the attached sheet of paper)

	YES	NO
1. Medical/Dental/Psychology license in any state	___	___
2. Other professional registration/license	___	___
3. DEA Certificate	___	___
4. Residency/Fellowship training	___	___
5. Academic appointment	___	___
6. Membership on any hospital medical staff	___	___
7. Clinical privileges, prerogative/rights on any medical staff	___	___
8. Board certification	___	___
9. Any other type of professional sanction (i.e. Peer Review Organization)	___	___
10. Have you resigned in order to avoid possible revocation, suspension or reduction of privileges at any hospital or institution?	___	___

PART IX: CRIMINAL ACTIONS: (If "Yes", please provide a full explanation on the attached sheet of paper)

	YES	NO
1. Have there been or are there any criminal charges or convictions pending against you?	___	___
2. Have you ever been convicted of a criminal offense?	___	___
3. Have you pled guilty, nolo contendere, been convicted, received probation before judgment or other diversionary disposition of any criminal act (excluding traffic violations)?	___	___
4. Have you pled guilty, nolo contendere, been convicted of, received probation before judgment or other diversionary disposition for driving while intoxicated, or for a controlled dangerous substance offense?	___	___

PART X: HEALTH STATUS: (If "Yes", please provide a full explanation on the attached sheet of paper)

	YES	NO
1. Do you have any physical/mental condition (including alcohol or drug dependence) that limits or adversely affects your ability to participate fully in the care of your patients?	___	___
2. Have you been hospitalized, institutionalized, or involved in a patient treatment program that limited your ability to participate fully in the care of your patients?	___	___
3. Are you presently, or have you within the last year, engaged in the use of illegal drugs?	___	___

PART XI: ADDITIONAL QUESTIONS: (If "Yes", please provide a full explanation on the attached sheet of paper)

	YES	NO
1. Have you been subject to sanctions as a Medicare or Medicaid provider?	___	___
2. Have you ever been the subject of a focused review by a Peer Review Organization (PRO) or similar agency including but not limited to Medicare, Medicaid, etc.?	___	___
3. Do you have ownership in any medical facility or joint ownership of any medical services, or equipment with a facility to which you might refer patients?	___	___
4. Have you been disciplined or counseled for engaging in harassment or discrimination on the basis of race, creed, color, religion, gender, or sexual orientation?	___	___
5. Have you been the subject of an administrative, civil or criminal complaint or investigation regarding sexual misconduct or child abuse? (If "Yes", provide full details including the plaintiff and court caption of any pending lawsuit on a separate piece of paper. Mark "Yes" if you have previously told us of the event but there has been activity or change.)	___	___

PART XII: PROFESSIONAL REFERENCES

List four persons, preferably at least 2 in your specialty, who have been in a position to judge or supervise your clinical performance within the past five years. Please do not include as references individuals related by blood or marriage, training colleagues, or persons previously listed in this application as program directors or chairmen. Also, please only use persons with the equivalent professional suffix as yourself (MD, DO, DDS, PhD., etc.). Please provide e-mail addresses for each reference to improve processing time.

1) Name and Title: _____
 Address: _____

 Phone/Fax/E-mail: _____

2) Name and Title: _____
 Address: _____

 Phone/Fax/E-mail: _____

3) Name and Title: _____
 Address: _____

 Phone/Fax/E-mail: _____

4) Name and Title: _____
 Address: _____

 Phone/Fax/E-mail: _____

Name: _____

Date: _____

Failure to complete this application form in a timely manner, withholding of requested information, or providing false or misleading information shall, by itself, constitute a basis for the denial of participation in the requested training program.

PART XIII: ATTESTATION (to be signed by all applicants)

By signing below, I, _____ attest that all information contained on this application is true to the best of my knowledge.

Signature of Applicant

Date

CONDITIONS OF TRAINING AND CONSENT TO RELEASE OF INFORMATION

By applying for training privileges at 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 participation in the training programs of the University of Maryland Medical System.
2. I agree that, if appointed, I will follow the Policies and Procedures 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.
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 to 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 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-training participant, 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.
11. I agree to allow the University of Maryland Medical Center to survey future employers for the purpose of assessing the quality of education that was provided to me.

Applicant's Signature: _____

Applicant's Name Printed: _____

Date: _____

REVISED – 2/07

FOR UNIVERSITY OF MARYLAND MEDICAL SYSTEM RESIDENTS/FELLOWS ONLY
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: _____

NAME _____ DATE _____

MALPRACTICE CLAIMS/SUIT HISTORY

(FAILURE TO DISCLOSE INFORMATION MAY RESULT
IN REJECTION OF YOUR APPLICATION)

Please copy this addendum form for each additional claim/suit

Name of Claimant: _____

Date of Incident: _____

Date Lawsuit/Claim Filed: _____

Name of Court and
Case Number: _____

Description: _____

Status of the Case: (with reference to you, specifically)

- _____ Pending
- _____ Closed Without Payment
- _____ Pre-Trial Settlement (\$ _____)
- _____ Verdict for Defendant
- _____ Verdict for Plaintiff (\$ _____)
- _____ Other (_____)

What was/is your status:

- _____ Sole Defendant
- _____ Co-Defendant (with _____)
- _____ Other: _____

Name and Policy # of
Insurance Carrier: _____
