

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

## RESIDENT/FELLOW CREDENTIALING APPLICATION

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

1. After reviewing the Frequently Asked Questions, 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\*:
  - Current Curriculum Vitae;
  - Copy of Educational Commission for Foreign Medical Graduate Certificate(if applicable)
  - House Staff Association Sign Up Form (optional)
  - Lab Coat Order Form
  - Copy of current Maryland license (if applicable);
  - Copy of Federal Drug Enforcement Administration (DEA) registration (if applicable);
  - Copy of Maryland CDS registration (if applicable);
  - Copy of Board Certification, if applicable;
6. Please return your application via First Class Postal Service. If necessary, please fax your application to 410.328.6433 and mail the original to our office.

**NOTE:** Health Assessment paperwork **should not be returned to this office.** Complete and keep this with you until your appointment with Employee Health.

# RESIDENT/FELLOW 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: \_\_\_\_\_

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

Date: \_\_\_\_\_

**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)

**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 \_\_\_\_\_

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

Date: \_\_\_\_\_

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 \_\_\_\_\_) Type of  
Date From Date To Serial or Svc # Branch of Service Discharge\*  
 \_\_\_\_\_

\*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 \_\_\_\_\_)

<b>NBME</b>	Part I _____ Date	Part II _____ Date	Part III _____ Date
<b>NBDE</b>	Part I _____ Date	Part II _____ Date	
<b>USMLE</b>	Part I _____ Date	Part II _____ Date	Part III _____ Date
<b>FLEX</b>	_____		
	Date		
<b>NBOME</b>	Part I _____ Date	Part II _____ Date	Part III _____ 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) \_\_\_\_\_

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

Date: \_\_\_\_\_

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. National Provider Identifier (NPI) Number \*: \_\_\_\_\_ or Check if NPI applied for: \_\_\_\_\_  
(required)

**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)

\*use additional sheet of paper if necessary

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

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

**3. Malpractice History:**

	<b>YES</b>	<b>NO</b>
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)

	<b>YES</b>	<b>NO</b>
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)**

	<b>YES</b>	<b>NO</b>
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)**

	<b>YES</b>	<b>NO</b>
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?	___	___

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

Date: \_\_\_\_\_

**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 three 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: \_\_\_\_\_

**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: \_\_\_\_\_  
\_\_\_\_\_

