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Medical Staff Services

Checklist for University of Maryland Medical Center Rotation

This checklist outlines the documents required for credentialing as a rotator with the University of Maryland Medical Center. All rotators must complete the credentialing process prior to beginning any clinical activity. **Please submit all documents in one package at least four weeks prior to your rotation.** Any missing documentation may delay the processing of the application. You will be notified of all missing documentation, and this documentation must be received one week prior to the start of the rotation.

Forms Needed:

- Rotator Application
- Unlicensed Medical Practitioner Form (not applicable for current Maryland residents, those who currently hold a Maryland license, or those in military training programs) **including \$100.00 check payable to the Maryland Board of Physicians**
- Rotator Evaluation completed by the program director

Documentation Needed:

- Current Curriculum Vitae
- Primary source verification of medical school graduation or notarized copy of medical school diploma
- PPD results from within the past year; If PPD positive, results from your most recent chest x-ray
- Copy of ECFMG certificate (if international medical graduate)
- Letter verifying malpractice insurance coverage or insurance certificate

For Current Participants in Maryland Graduate Medical Training Programs

- Copy of UMP form submitted to Maryland Board of Physicians or copy of roster from Board of Physicians confirming UMP registration

If you have any questions, please contact the appropriate the Medical Staff Coordinator at 410-328-2902. Thank you.

PART I: PERSONAL INFORMATION

Name (Last, First, Middle): _____

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

Social Security Number: _____ Previous name that degree would be under: _____

Dates of Rotation/Department: _____

Home Address: _____

Home Phone: _____ Beeper: _____ E-mail: _____

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

PART II: EDUCATION

1. Medical/Dental School

School Name _____

Mailing Address _____

Dates Attended (MM/YY) From _____ To _____

If you are a foreign medical graduate, please complete the following:

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

2. Current Residency/Fellowship Program

Institution Name _____

Program type (Specify):

Internship Residency Fellowship Specialty Training

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

Mailing Address _____

Program Director _____

Phone/Fax/Email _____

Name: _____

Date: _____

3. Previous Residency/Fellowship Training Programs

Institution/Mailing Address	Residency/Fellowship	Specialty	Dates

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 _____)

Institution/Mailing Address	Specialty	Dates (From/To)

2. 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)**

Name: _____ Date: _____

PART IV: 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. National Provider Identifier (NPI) Number: _____

PART V: 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>
_____	_____	_____	_____
_____	_____	_____	_____

PART VI: PROFESSIONAL LIABILITY COVERAGE

1.

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)

2. **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 2a – 2e is yes, please provide full information on the Malpractice Claims/Suit History Addendum (page 7)
****If any answer to 2f or 2g is yes, please attach an explanation on a separate page****

Name: _____

Date: _____

PART VII: 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 VIII: 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 IX: 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 X: 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.)	___	___

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 rotation.

PART XI: 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: _____

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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: _____
