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

Checklist for University of Maryland Medical Center Rotation

This checklist outlines the documents required for credentialing as a rotator/visiting resident with the University of Maryland Medical Center. Rotators must complete the credentialing process prior to beginning any clinical activity. **Please submit all documents to your UMMC Contact in one package 60 days 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
- ☐ Rotator Evaluation completed by the program director

Documentation Needed:

- ☐ Current Curriculum Vitae
- ☐ Copy of primary source verification of medical school graduation or notarized copy of medical school diploma
- ☐ **Proof of Immunizations** and PPD results from within the past year; If PPD positive, results from your most recent chest x-ray
- ☐ **Flu Vaccination Documentation** (required if rotating October 1 through March 31)
- ☐ Copy of ECFMG certificate (if international medical graduate)
- ☐ Letter verifying malpractice insurance coverage or insurance certificate
- ☐ NPI information: All UMMC rotators (**excluding Canadians)** are required to have a NPI number. If the resident does not have an NPI, one must be obtained. An application can be completed online at https://nppes.cms.hhs.gov.

All documents should be mailed to your Rotation Coordinator at UMMC. Paperwork may be faxed or emailed, originals not required.

UNIVERSITY OF MARYLAND MEDICAL CENTER
VISITING RESIDENT/FELLOW APPLICATION FORM

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)**

____

____

____

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

Name: ____ Date: _____________________

3. National Provider Identifier (NPI) Number: ______________________________________

PART V: BOARD CERTIFICATION AND PROFESSIONAL MEMBERSHIPS

1. Board Certification Status Board Name	Date Certified	Date Recertified	If Not Certified, Eligible Until:
___________________________________	__________	___________	________________
___________________________________	__________	___________	________________

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:	☐Claims Made ☐Occurrence ☐Extended Reporting Policy (Tail)

PART VII: ADDITIONAL QUESTIONS
Please attach an explanation for any **yes** answers.

		YES	**NO**
1.	Have you ever faced disciplinary action or been placed on probation during training?	____	____
2.	Have you ever resigned, been forced to resign, or been terminated from a training program?	____	____
3.	Have you ever resigned, been forced to resign or been terminated from any employment?	____	____
4.	Have you voluntarily or involuntarily relinquished or had any disciplinary action taken against any license or clinical privileges?	____	____
5.	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?	____	____
6.	Are there any pending malpractice actions or findings of professional misconduct against you?	____	____
7.	Have you pled guilty, nolo contendere, been convicted, received probation before judgment or other diversionary disposition of any criminal act?	____	____
8.	Are there any criminal charges or convictions pending against you?	____	____

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

Revised 5-2013

CONDITIONS OF APPOINTMENT AND CONSENT TO RELEASE OF INFORMATION

By applying for appointment or reappointment to the medical or affiliate staff of the University of Maryland Medical System Corporation d/b/a University of Maryland Medical Center, Maryland General Hospital d/b/a University of Maryland Medical Center Midtown Campus, James Lawrence Kernan Hospital, Inc., d/b/a University of Maryland Rehabilitation and Orthopaedics Institute, Baltimore Washington Medical Center, Inc., d/b/a University of Maryland Baltimore Washington Medical Center, Memorial Hospital of Easton, d/b/a University of Maryland Shore Medical Center at Easton, Dorchester General Hospital, d/b/a University of Maryland Shore Medical Center at Dorchester, Chester River Hospital Center, d/b/a University of Maryland Shore Medical Center at Chestertown, or Civista Medical Center, Inc. d/b/a University of Maryland Charles Regional Medical Center, University of Maryland St. Joseph Medical Center, LLC, d/b/a University of Maryland St. Joseph Medical Center, University of Maryland Upper Chesapeake Heath System, Inc., d/b/a University of Maryland Upper Chesapeake and University of Maryland Harford Memorial Hospital, and any successor, or assignees of the foregoing, and any other designee of the University of Maryland Medical System Corporation, or of any facilities associated with the University of Maryland Medical System Corporation for medical staff membership, privileging or managed care credentialing purposes, (collectively and hereinafter "UMMS Affiliated Hospitals"), 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 (which will be identified as such at the sole discretion of the UMMS Affiliate Hospital receiving the application form membership) constitute cause for denial of appointment or cause for summary dismissal from the medical staff of the UMMS Affiliated Hospital.

2. I agree that, if appointed, I will read and follow the Medical Staff Bylaws, any Rules and Regulations and all policies and procedures applicable to the medical staff, as they may be changed and updated from time to time.

3. I authorize the UMMS Affiliated Hospitals and its representatives, including members of the medical staff, to consult with other hospitals, including both UMMS Affiliated Hospitals and non-UMMS Affiliated 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 all representatives of the UMMS Affiliated 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 UMMS Affiliated Hospital in good faith and without malice, and I consent to the release of any information including but limited to medical peer review material, which any other employer, insurance carrier, 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 UMMS Affiliated Hospital and/or any other consumer reporting agency engaged by the UMMS Affiliated Hospital, 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 UMMS Affiliated Hospital and its representatives, including members of the medical staff and the Maryland Medicine Comprehensive Insurance Program, to other hospitals and their representatives, and to others*, including professional liability insurance carriers representing the Hospital, or persons affiliated with the UMMS Affiliated Hospital, 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, health care institution, or agency 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, and physical condition, ability to work compatibly with my peers and other UMMS Affiliated Hospital 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 University of Maryland School of Medicine who will provide billable services through a professional association under the Medical Service Plan, "others" includes third party payers with whom my professional association (and/or Faculty Physicians, Inc. (FPI) on behalf of my professional association) contracts, for the purpose of enabling these third party payers to accept me as a participating provider.

6. I agree to participate in and cooperate with the UMMS Affiliated Hospital's quality, utilization, and risk management programs. I agree to hold the UMMS Affiliated Hospital and representatives of the UMMS Hospital 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 UMMS Affiliated Hospital 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 UMMS Affiliated Hospital any occurrences, incidents, actions or other information relating in any way to questions in this application or responses I have provided to any such questions, if such occur following the submission 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 UMMS Affiliated Hospital or only those privileges eventually approved by the Governing Board of the UMMS Affiliated Hospital.

10. I understand that as a member of the Medical Staff, I am participating with the UMMS Affiliated Hospital in an organized health care arrangement as defined by the Privacy Regulations under HIPAA. I agree to comply with the UMMS Affiliated Hospital policies on protected health information and its Notice of Information Privacy Practices with regard to the UMMS Affiliated Hospital patients.

11. My credentials file is maintained by the Medical Staff Services Department and I authorize that office to share all documents contained in my credentialing file with all UMMS Affiliated Hospital entities with whom I am submitting an application for medical staff membership. I also authorize all UMMS Affiliated entities, all Medical Staffs and their authorized representatives to share peer review evaluations, data, and any other documentation concerning my practice, as necessary to process any applications that I have submitted for membership and/or privileges at any UMMS Affiliated Hospital.

Applicant's Signature: ____

Applicant's Name Printed: ____

Date: ______________

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