

# *University of Maryland Medical Center*



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

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

**University of Maryland Medical Center  
Medical Staff Services  
110 South Paca Street, 8<sup>th</sup> Floor  
Baltimore, MD 21201  
Telephone: (410) 328-2902  
Fax: (410) 328-6433  
Website: [www.umm.edu/professionals/medstaff](http://www.umm.edu/professionals/medstaff)**



## MEDICAL/AFFILIATE STAFF APPLICATION: INSTRUCTIONS

Please read the following instructions carefully. Proper completion and submission of the credentialing application materials is essential for consideration of appointment to the Medical or Affiliate Staff at UMMC.

1. Complete BOTH the Maryland Hospital Credentialing Application AND Medical Staff Membership Addendum in full. **DO NOT USE WHITEOUT.** If a response is “no”, “none” or “not applicable”, please state. **If a mistake is made, 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. Type or print all responses. **UMMC DOES NOT ACCEPT DIGITAL SIGNATURES. ALL SIGNATURES MUST BE ORIGINAL** and dated within 10 days of submission of the application.
3. For all requested affiliations, you must furnish complete name, street address, city, state, zip code, phone and fax number. **Include EMAIL ADDRESSES for all residency/fellowship/affiliations and references. The majority of verification evaluations are sent via email from this office.**
4. Use additional paper, if necessary, to supply complete responses.
5. Document all professional clinical employment from graduation of professional degree to the present time. Any gaps in clinical employment greater than three (3) months must be documented.
6. **References:** All applicants are required to provide the name/address/email address for four (4) peers to support their application for appointment. Do not designate Department Chairman or current supervisors.  
**MEDICAL STAFF:** Please consider utilizing professional references other than those provided to support a University of Maryland School of Dentistry/Medicine Faculty Appointment.  
**CRNP/PA:** New graduates must provide the name/contact of the preceptor of the CRNP program to confirm current competence.  
**CRNA:** CRNA applicants must provide the name/contact of at least one physician who has knowledge of current competence.
7. In addition to the completed application and addendum, the following documentation (if applicable) must be returned in order for an application to be processed\*: **DO NOT DELAY IN RETURNING THE CREDENTIALING APPLICATION PENDING RECEIPT OF THESE ITEMS.**
  - a) Current Curriculum Vitae noting month/year of all training and hospital affiliations;
  - b) Maryland professional license (s); \*
  - c) Federal Drug Enforcement Administration (DEA) registration; \*/\*\*
  - d) Maryland CDS registration; \*
  - e) Any/all Board Certification (s), where applicable;
  - f) Any/all other state professional license (s);
  - g) Professional liability insurance certificate issued to the University of Maryland Medical System, Maryland Medicine Comprehensive Insurance Program (MMCIP) consent form (page 20), or proof of coverage provided by the University of MD Dental School. **For applicants expecting to be covered under MMCIP, please confirm underwriting requirements (page 19), which are required to be supplied by the applicant. Confirmation of coverage will be contingent on these requirements.**
  - h) Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable.
  - i) Current Federally Issued Identification (Driver’s License or Passport)
  - j) **Completed Delineation of Privileges form/ Copy of Written Agreement/Job Description/Copy of BON Attestation submitted to the Board of Nursing**
  - k) Current photo (passport size is acceptable). This photo will not be used during the decision making process, simply to identify the applicant as the individual in the credentialing material.
8. 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. Please check the Medical Staff Services website for more information.

9. Print and complete UMMC Employee Health Pre-Employment physical forms and schedule an appointment with UMMC Employee Health Services at 410/328-6151. This requirement is applicable to all AHPs and Medical Staff Members with the exception of those applying for Volunteer Faculty positions. **DO NOT RETURN THESE FORMS TO THE MEDICAL STAFF SERVICES DEPARTMENT.**

Volunteer Faculty ONLY: Provide evidence of current PPD test results within the past year.

- \* **DO NOT DELAY IN RETURNING THE CREDENTIALING APPLICATION** if the following items have not been obtained: Maryland state professional licensure, Federal DEA registration, Maryland state CDS registration or written agreement/attestation approval with the Board of Nursing/Medicine. Please forward said items under separate cover when received.
- \*\* If the applicant will be relocating to Maryland from another state, 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.

## **General Underwriting Requirements for New Hire Healthcare Provider Applying for MMCIP Coverage**

### **All Providers:**

1. DHMH Credentialing Application. You complete this and send it to Medical Staff Office, which forwards it to MMCIP.
2. Signed MMCIP “Consent to Release Information.” You complete this and send it to Medical Staff Office, which forwards it to MMCIP.
3. Evidence of insurance coverage from your current insurance program (including locum tenens or volunteer work). This includes hospital self-insurance programs. You provide the Medical Staff Office with a certificate of insurance from the insurer. The MSO will forward it to MMCIP.
  - a. Some policies are “claims made.” This means that the policy insures you for any professional liability claim brought against you during the period you were covered. For this type of policy to continue to insure you for claims arising from this period of your career, you will need “extended reporting coverage” (often referred to as a “tail”). If you have claims made coverage, you will need to provide evidence of any tail coverage to the Medical Staff Office, which will forward it to MMCIP.
  - b. You are still expected to provide a list of all your past professional liability carriers as required in the DHMH Credentialing Application, section VIII.G.
4. Your Claims History for the most recent 5 years of your professional career. This is issued by the insurer (including any hospital self insurance program) for the entity for whom you worked. It must include all open claims and all claims closed within the past 5 years. The Medical Staff Office will request this information on your behalf, and forward it to MMCIP.
5. Delineation of Privileges approved by your department. The Medical Staff Office will forward this to MMCIP.
6. Board Approval, with effective date. The Medical Staff Office will forward this to MMCIP.

### **All Mid-Level Applicants:**

Items nos. 1 through 6 above; AND,

7. Nurse practitioners must have proof of a current Approved Attestation with the Board of Nursing. Physician Assistants must have proof of an Approved Delegation Agreement with the Board of Physicians.
8. Mid-level providers do not need to supply certificates of insurance or claims histories for any position they held as staff (e.g., staff nursing, respiratory therapy, radiography).

### **Applicants to All UMMS Hospitals EXCEPT UMMC University Campus:**

Items nos. 1 through 6 above, and Items 7 – 8 for Mid-Level Applicants; AND,

9. MMCIP Application for Coverage, signed by applicant and CMO. You complete this and send it to Medical Staff Office, which forwards it to MMCIP.
10. Physician Contract or “Term Sheet” to document your employment status with the hospital. You complete this with your employer, and the Medical Staff Office forwards it to MMCIP.

***Please note: MMCIP may request additional information as indicated during the underwriting process. If you have any questions about this process, please call MMCIP at 410-328-3391.***



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 address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone number \_\_\_\_\_ Cell phone \_\_\_\_\_

E-mail \_\_\_\_\_

Preferred mailing address (check one):  Home  Primary office  Office 2

Preferred E-mailing address (check one):  Home  Primary office  Office 2

Preferred phone number (check one):  Cell  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 \_\_\_\_\_

Web Site \_\_\_\_\_

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 \_\_\_\_\_

Web Site \_\_\_\_\_

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 \_\_\_\_\_

Web Site \_\_\_\_\_

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

**1. 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 \_\_\_\_\_

Phone no. \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

**2. 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 \_\_\_\_\_

Phone no. \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

**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 \_\_\_\_\_ Was this program ACGME accredited? [ ]Yes [ ]No

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 listed 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 \_\_\_\_\_ Was this program ACGME accredited? [ ] Yes [ ] No

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 \_\_\_\_\_ Was this program ACGME accredited? [ ] Yes [ ] No

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 \_\_\_\_\_ Was this program ACGME accredited? [ ] Yes [ ] No

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 of the programs listed, please provide full details on a separate sheet of paper.***



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

#### IV. Affiliations, Privileges, and Employment

- ACCOUNT FOR ALL TIME PERIODS, IN CHRONOLOGICAL ORDER, SINCE COMPLETION OF YOUR PROFESSIONAL EDUCATION. LIST ALL **HEALTHCARE FACILITIES** AT WHICH YOU HOLD, OR HAVE HELD PRIVILEGES. INCLUDE ANY MOONLIGHTING OR *LOCUM TENENS* WORK.
- 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/Facility 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/Facility 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/Facility 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>Professional License</b>				
<b>Maryland License Number</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>NRP</b>				
<b>Medicaid Provider Number</b>				
<b>Tax ID Number</b>				
<b>NPI Number</b>				

***Attach a copy of each document you maintain.***

**VI. U.S. MILITARY SERVICE**       YES       NO

Dates: (MM/YYYY) From \_\_\_\_\_ To \_\_\_\_\_

Current status: \_\_\_\_\_

Highest rank: \_\_\_\_\_

Branch: \_\_\_\_\_



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. THE HOSPITAL TO WHICH YOU ARE APPLYING MAY REQUIRE MORE THAN FIVE YEARS OF LIABILITY COVERAGE HISTORY. **REFER TO THE HOSPITAL-SPECIFIC INSTRUCTIONS THAT CAME WITH THIS APPLICATION.**
- 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 all available professional liability carriers.*

Current Carrier:	Name:
	Full Address
	City State Zip
	Phone Number Fax
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
	Phone Number Fax
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
	Phone Number Fax
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
	Phone Number Fax
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
	Phone Number Fax
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)

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

**H. CLAIMS HISTORY:** N/A

- COMPLETE THE FOLLOWING INFORMATION AS IT PERTAINS TO YOUR PROFESSIONAL LIABILITY AND CLAIMS HISTORY.
- PROVIDE INFORMATION ON ANY AND ALL PROFESSIONAL LIABILITY SUITS IN WHICH YOU WERE NAMED, REGARDLESS OF THE OUTCOME. YOU MAY INCLUDE LEGAL DOCUMENTATION.
- IF MORE SPACE IS REQUIRED, PLEASE COPY THIS PAGE BEFORE COMPLETING.

Date of alleged incident \_\_\_\_\_

Plaintiff(s) \_\_\_\_\_ Patient's Name \_\_\_\_\_

State/Country in which suit was initiated \_\_\_\_\_ Date \_\_\_\_\_

Health Care Alternative Dispute Resolution or Court case number \_\_\_\_\_

Insurance carrier and address \_\_\_\_\_

You were:  Primary defendant  Co-defendant

Description of allegation or complaint:

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Your professional relationship with patient:  Attending  Consultant  Resident  
 Other \_\_\_\_\_

Describe your clinical care in this case:

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Current status of suit:

- Filed  Deposed Settled in favor of:  Plaintiff  
 Settled out of court  Awaiting trial  Defendant  
 Dismissed or withdrawn  Other: please describe \_\_\_\_\_

Date of resolution: \_\_\_\_\_ Amount of settlement (if applicable) \_\_\_\_\_

**IX. ADDITIONAL QUESTIONS**

*All affirmative answers must be fully explained on a separate sheet of paper.*

**A. PROFESSIONAL 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: TJC 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 been convicted of, pled guilty to, or pled nolo contendere to, any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse, or a sexual offense or misconduct? | <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. 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"/> |
| 5. Have you ever been convicted of a felony?  | <input type="checkbox"/> | <input type="checkbox"/> |

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

## X. CONTINUING EDUCATION

*The hospital to which you are applying may require detailed information regarding this section. Refer to the hospital-specific instructions that came with this application.*

Have you met the CEU/CME requirements for maintaining your professional license? YES NO  
   
Have you participated in CEUs/CMEs pertinent to your specialty?    
If "NO" to either of above, please explain:

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## XI. PROFESSIONAL REFERENCES

- LIST ONLY THOSE WHO CAN SPEAK TO YOUR CLINICAL COMPETENCE

*Each hospital has its own requirements for this section. Refer to the hospital-specific instructions that came with this application. Please note: TJC requires peer references for all credentialed practitioners.*

Name: \_\_\_\_\_  
Title: \_\_\_\_\_ Supervisor  Peer   
Mailing address: \_\_\_\_\_  
City: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name: \_\_\_\_\_  
Title: \_\_\_\_\_ Supervisor  Peer   
Mailing address: \_\_\_\_\_  
City: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name: \_\_\_\_\_  
Title: \_\_\_\_\_ Supervisor  Peer   
Mailing address: \_\_\_\_\_  
City: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name: \_\_\_\_\_  
Title: \_\_\_\_\_ Supervisor  Peer   
Mailing address: \_\_\_\_\_  
City: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_



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 in any way to make decisions about an applicant's qualification for credentialing.*

**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>   |   |



UNIVERSITY of MARYLAND  
MEDICAL CENTER

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

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

**University of Maryland Medical Center  
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 UMMC, 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 a University of Maryland Medical System Hospital?  
\_\_\_\_ Yes \_\_\_\_\_ No If yes, please list facility (ies): \_\_\_\_\_
- B. Please indicate the percentage of time you will spend at each of the following UMMS facilities (if applicable):
- \_\_\_\_ UM Medical Center      \_\_\_\_ UM Rehab & Orthopedic Institute      \_\_\_\_ UM Mid-Town Campus  
\_\_\_\_ UM Baltimore Washington      \_\_\_\_ UM St. Joseph Medical Center      \_\_\_\_ UM Charles Regional  
\_\_\_\_ UM Shore Regional      \_\_\_\_ Upper Chesapeake/Harford Memorial

### **Part V**

#### **Correspondence Preference**

**Preferred Mailing Address:**

\_\_\_\_ Home  
\_\_\_\_ Primary Practice  
\_\_\_\_ Office 2

**Preferred Correspondence Type:**

\_\_\_\_ U.S. Mail  
\_\_\_\_ Fax  
\_\_\_\_ Email

Please be sure to keep our office updated with any changes to these fields to be sure you receive your correspondence timely.



## CONDITIONS OF APPOINTMENT AND CONSENT TO RELEASE OF INFORMATION

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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 Health 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: \_\_\_\_\_

Revised 4/2014

## Maryland Medicine Comprehensive Insurance Program

*A joint venture between the University of Maryland Medical System and University of Maryland Faculty Physicians, Inc.*

### **Consent to Release Information**

In consideration of my application for professional liability coverage through the Program of Self-Insurance administered by the Maryland Medicine Comprehensive Insurance Program (MMCIP), I hereby authorize the release of information regarding my claims and insurance history and related information to appropriate representatives of MMCIP. 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 release from all liability MMCIP, its employees, agents, officers, representatives, attorneys, participating entities, subsidiaries, successors or assigns for 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, in good faith, provide information to MMCIP concerning my claims and insurance history, and related information, including privileged and/or confidential information.

If granted coverage through MMCIP, I agree to abide by any existing conditions of coverage of MMCIP, and applicable professional liability insurance policies as they currently exist or are amended from time to time, and otherwise comply fully with the Office of Risk Management and its scheduled programs including attendance at mandatory Risk Management Orientation and Reappointment Sessions. Further, I agree to fully cooperate with the investigation and defense of any medical malpractice claim or suit. Failure to do so may jeopardize my coverage and future participation in this program of self-insurance.

Additionally, as a condition of coverage by MMCIP, I agree to report any known occurrence or circumstance which has the potential of becoming a liability claim or lawsuit against me, the hospital, any practice plan, or department as soon as practicable, but by no later than 7 days of its occurrence, to the Office of Risk Management at (410) 328-4704.

Reportable circumstances include, but are not limited to:

- Death (unexpected or unexplained)
- Paralysis, paraplegia, quadriplegia
- Spinal cord injury
- Brain damage
- Total or partial loss of limb or loss of the use of limb
- Sensory organ or reproductive organ impairment
- Disability or disfigurement
- Any assertion by a patient that he/she has been medically injured
- Any injury to a part of the anatomy not undergoing treatment
- Misdiagnosis of patient's condition resulting in increased morbidity
- Injury/death to either child or mother during delivery
- Any assertion by the patient or family that consent for treatment (medical or surgical) was not given
- Any birth when the baby is stillborn, or expires shortly after delivery
- Nerve or Neurological Deficit
- Allegations of physical and/or sexual abuse

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

I have completed this application truthfully and understand that any coverage decisions made by MMCIP will be based in part on this application. I agree to advise MMCIP immediately of any changes that would alter my responses on the application. Upon acceptance of my application, I agree to comply fully with the Conditions of Coverage of MMCIP and the rules, regulations and requirements of the Office of Risk Management.

Name (printed): \_\_\_\_\_

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

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





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

www.ummc.edu/med\_staff\_services

## UMMC CONTROLLED SUBSTANCES PRESCRIBING STATUS

In an effort to document the prescribing intentions of each practitioner at UMMC and to communicate required processes regarding controlled substances privileges, please choose one of the following. **Choose 1)** if your DEA and/or CDS certificates are pending (be sure to circle which or both). **Choose 2)** if you do not prescribe controlled substances in Maryland. Sign, date, and return with your application or to the fax number or address given above.

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

1)      I, \_\_\_\_\_ attest that **I have applied for** the proper Maryland State CDS & Federal DEA registrations in order to prescribe controlled substances in the State of Maryland. However since my CDS DEA DEA correction/renewal (check pending item) certificate(s) is pending, I understand that until I have supplied the UMMC Medical Staff Services Department with a copy of each I may not prescribe controlled substances nor perform moderate sedation at UMMC. In addition I understand that if a patient I am treating, prior to obtaining appropriate registrations, requires controlled substances and/or moderate sedation I will consult a physician with prescribing privileges and/or the approved privilege to facilitate the order. (Items pending)

**2) Requires Approval by Division Chief and/or Chair (obtained by Medical Staff Services)**

     I, \_\_\_\_\_ attest that **I do not prescribe controlled substances** nor perform moderate sedation in the State of Maryland and therefore do not require neither a Maryland State CDS nor Federal DEA registrations. The Department of \_\_\_\_\_ is aware of my prescribing status. In addition I understand that if a patient requires controlled substances, I will consult a physician with prescribing privileges to facilitate the order. I also understand that in the future, if I wish to prescribe controlled substances or perform moderate sedation I must apply for, obtain, & forward to the UMMC Medical Staff Services Department the proper registrations before doing so. (Non-prescribing)

\_\_\_\_\_  
 Applicant's Signature

\_\_\_\_\_  
 Date

#2 Approved by:

\_\_\_\_\_  
 Division Chief (if applicable)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Chair, Department of \_\_\_\_\_

\_\_\_\_\_  
 Date