



3000 California St., 2<sup>nd</sup> Floor  
San Francisco, CA 94115  
415-567-1171

APPLICATION FOR APPOINTMENT TO MEDICAL STAFF

Instructions:

- 1. Information must be typed or printed.
- 2. All questions must be answered and forms must be signed where indicated.
- 3. If more space is needed, please attach additional sheets and reference the questions being answered.
- 4. If there is a break in the continuity of your medical education, internship, residency, hospital affiliations, medical practice, etc., please explain.

IDENTIFYING INFORMATION

Last Name First Name Middle Initial S.S. #

Professional Group Name and Address

City State Zip

Tel. # Fax # Email

Home Address

City State Zip

Tel. # Cell # Pager#

Date of Birth Place of Birth Citizenship

MEDICAL LICENSURE/CERTIFICATION

License Number Expires State of Issuance

DEA Number Expires

OTHER STATE MEDICAL LICENSES – PAST AND PRESENT

State Registration/Number Date State Registration/Number Date

**PREMEDICAL EDUCATION**

College/University

Degrees/Honors

Address

Date of Graduation

**MEDICAL EDUCATION**

College/University

Degrees/Honors

Address

Date of Graduation

**INTERNSHIP**

Hospital

Dates Attended

Address

Full Name of Program Director

Type

Kind (Medical, Surgical, etc.)

**RESIDENCY PROGRAMS**

Hospital

Dates Attended

Address

Description

Hospital

Dates Attended

Address

**TRAINING, FELLOWSHIPS, PRECEPTORSHIPS, POSTGRADUATE EDUCATION**

List in chronological order. Give complete school or hospital name and address, including ZIP codes, beginning and ending dates, and name of the immediate supervisor.

School or Hospital (1)

Address

Dates

Superior

School or Hospital (2)

Address

Dates

Superior

## HOSPITAL AND UNIVERSITY AFFILIATIONS

List all present and past affiliations in chronological order. Indicate "Staff Status" as : Active/Courtesy, etc. or Academic Title. Use additional sheet if necessary.

Name of Institution (1)	Address
Dates Affiliated	Staff Status
Department	Dept. Chief/Chair (Full Name)
Name of Institution (2)	Address
Dates Affiliated	Staff Status
Department	Dept. Chief/Chair (Full Name)
Name of Institution (3)	Address
Dates Affiliated	Staff Status
Department	Dept. Chief/Chair (Full Name)

## PREVIOUS MEDICAL PRACTICE

Type	Location (Address/Group Name)	Dates Practicing
Type	Location (Address/Group Name)	Dates Practicing

## CERTIFICATION

Certified by American Board of (Specialty)	Certification #	Date of Certification	Expires
If Not Certified, Give Present Status	Date	Date of Exam	

## PROFESSIONAL PEER REFERENCES

Name (1)	Professional Relationship	Address
Name (2)	Professional Relationship	Address
Name (3)	Professional Relationship	Address

**PROFESSIONAL LIABILITY**

Insurance Carrier

Amount of Coverage

Policy #

Expiration Date

Have any professional liability lawsuits been filed against you during the past ten years (including those closed)?.....  Yes  No

Are there any now that are still pending?.....  Yes  No

Has any judgement or settlement ever been made against you in any professional liability cases?.....  Yes  No

Have you ever been denied professional insurance, or has your policy ever been cancelled?.....  Yes  No

If yes to any of the above, please explain on a separate sheet.

**PROFESSIONAL SANCTIONS**

Has your licensure to practice medicine in any jurisdiction ever been limited, suspended, revoked, or surrendered?.....  Yes  No

Have you ever been refused membership on a hospital medical staff?.....  Yes  No

Has your request for any specific clinical privilege ever been denied or granted with stated limitations?.....  Yes  No

Have your privileges at any hospital ever been suspended, diminished, revoked, or not renewed?.....  Yes  No

Has your narcotics registration ever been suspended or revoked?.....  Yes  No

Have you ever been denied membership or renewal thereof, or been subject to disciplinary action (other than discipline for failure to complete medical records) in any medical organization of health insurance plan?.....  Yes  No

Have you ever received a criminal conviction other than for minor traffic violations?.....  Yes  No

Have you been sanctioned by either the Medicare or Medicaid program?.....  Yes  No

If yes to any of the above, please explain on separate sheet.

**HEALTH STATUS**

Have you had an illness or physical disability that impairs, or could impair, your ability to practice your medical specialty?.....  Yes  No

If yes to any of the above, please explain on a separate sheet.

By applying for clinical privileges, I hereby signify my willingness to appear for interviews in regard to my application, and authorize the organization, its medical staff and their representatives to consult with members of management and members of medical staff of other hospitals or institutions with which I have been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to inspection by the Organization, its medical staff, and its representatives of all records and documents, including medical and credential records at other hospitals, which may be material to an evaluation of my qualifications for staff membership. I hereby release from liability all representatives of the Organization and its medical staff, in their individual and collective capacities, for their acts performed in good faith and without malice in connection with evaluating my application and my credential and qualifications, and I hereby release from any liability any and all individuals and organizations who provided information to the Organization or to members of its medical staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges. I hereby consent to the release of information by other hospitals, other medical associations, and other authorized persons, on request, regarding any information the Organization may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability the Organization for so doing. I understand and agree that I, as an applicant for clinical privileges, have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics, and other qualifications and for the resolution of any doubts about such qualifications.

By accepting appointment and/or reappointment to the medical staff at Pacific Heights Surgery Center, I hereby acknowledge and represent that I have read and am familiar with the bylaws, rules and regulations of the Organization, as well as the principles, standards and ethics of the national, state and local associations and state law and regulations that apply to and govern my specialty and/or profession, which are the "Governing Standards." I further agree to abide by the "Governing Standards" as may be enacted from time to time.

In addition, I agree to notify the Organization of any circumstances that would change my status in licensure, DEA, Medicare participation, liability insurance coverage or Board certification status or hospital privileges.

I understand and agree that any significant misstatements in or omissions from this application shall constitute cause for denial of appointment or cause for summary dismissal from the medical staff with no right of appeal. All information submitted by me in this application is true to the best of my knowledge and belief.

I further authorize a photostatic copy of the requests, authorizations, and releases to this application to serve as the original.

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Signature of Applicant

Date

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Print Name

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Medical Director

Date

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Governing Body

Date