

**Silver Cross Hospital**  
1200 Maple Road  
Joliet, Illinois 60432  
Medical Staff Office (815) 740-7097

**PRE-APPLICATION FOR MEDICAL STAFF APPOINTMENT**

All information should be typed or legibly printed. If more space is needed, attach additional sheets and make reference to the questions being answered.

Date \_\_\_\_\_

Name in Full \_\_\_\_\_

Maiden or Other Name/s Used \_\_\_\_\_

Pager \_\_\_\_\_

Applying to the Department of \_\_\_\_\_

Primary Specialty \_\_\_\_\_

Staff Category Applying To:     Associate (**Must have 6 admits/year**)    Consulting (No admitting privileges)

Will you be joining a practice with a physician (s) currently on the Medical Staff? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please name: \_\_\_\_\_

Office #1 Address \_\_\_\_\_

Office Phone \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Home Fax \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ UPIN # \_\_\_\_\_

Are you presently a citizen? \_\_\_\_\_

If not a citizen of the U.S., please indicate the **status of your visa** at the present time **and attach a copy**.

**Has your application for medical staff membership and/or privileges at any hospital or any other health care facility ever been rejected, modified, or been voluntarily withdrawn? Yes \_\_\_\_\_ No \_\_\_\_\_**

**LICENSES FOR PRACTICE**

State: \_\_\_\_\_

State: \_\_\_\_\_

License Number \_\_\_\_\_

License Number \_\_\_\_\_

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

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

**Please answer each of the following questions in full. If the answer to any of them is yes, please provide a full explanation of the details on a separate sheet and attach. *Please keep in mind that in this age of technology, access to historical and current information is readily available.***

Have any disciplinary actions been initiated or are any pending against you by any state licensure board?

Yes \_\_\_\_\_ No \_\_\_\_\_

Has your license to practice in any state ever been denied, or voluntarily or involuntarily, limited, suspended or revoked? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever voluntarily relinquished your licensure/registration to any state? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (i.e. Medicare, Medicaid)? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program? Yes \_\_\_\_\_ No \_\_\_\_\_

DEA Registration Number \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Has your Illinois Controlled Substance Certificate or your DEA license ever been suspended, modified, terminated, restricted, currently challenged or subject to investigation? Yes \_\_\_\_\_ No \_\_\_\_\_**

**Have you ever been named as a defendant in any criminal proceeding? Yes \_\_\_\_\_ No \_\_\_\_\_**

Have any formal or written complaints been filed against you with any State Medical Board or the National Practitioner Data Bank? Yes \_\_\_\_\_ No \_\_\_\_\_

*Attach copies of your current state license(s), Illinois Controlled Substance Certificate and DEA License.*

EVERY PERIOD SINCE MEDICAL SCHOOL MUST BE VERIFIABLE

**EDUCATIONAL DATA - PLEASE SUBMIT COMPLETE ADDRESSES**

Professional School

\_\_\_\_\_ Date of Graduation \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INTERNSHIP** (If more than one, please list on a separate sheet and answer the question below).

Institution \_\_\_\_\_

Complete Address \_\_\_\_\_

Type of Internship: Rotating \_\_\_\_\_ Special \_\_\_\_\_ Other \_\_\_\_\_

Dates: From \_\_\_\_\_ To \_\_\_\_\_

**During your internship were you ever suspended, placed upon probation, formally reprimanded, asked to resign? Yes \_\_\_\_\_ No \_\_\_\_\_**

**RESIDENCY** (If more than one, please list on a separate sheet and answer the question below).

Institution \_\_\_\_\_

Complete Address \_\_\_\_\_

Type of Residency \_\_\_\_\_

Department Director/Program Director \_\_\_\_\_

Dates: From \_\_\_\_\_ To \_\_\_\_\_

**During your residency were you ever suspended, placed upon probation, formally reprimanded, asked to resign? Yes \_\_\_\_\_ No \_\_\_\_\_**

If yes, please provide a full explanation of the details on a separate sheet and attach.

**FELLOWSHIP** (If more than one, please list on a separate sheet and answer the question below).

Institution \_\_\_\_\_

Complete Address \_\_\_\_\_

Type of Fellowship \_\_\_\_\_

Department Director/Program Director \_\_\_\_\_

Dates: From \_\_\_\_\_ To \_\_\_\_\_

**During your fellowship were you ever suspended, placed upon probation, formally reprimanded, asked to resign? Yes \_\_\_\_\_ No \_\_\_\_\_**

**BOARD CERTIFICATION**

Names of specialty boards by which you are certified:

\_\_\_\_\_ Date \_\_\_\_\_ Expiration \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_ Expiration \_\_\_\_\_

**Have you ever been examined by any specialty board, but failed to pass? Yes \_\_\_\_\_ No \_\_\_\_\_**

**WORK HISTORY** (ONLY THAT PERTAINING TO YOUR PROFESSIONAL DEGREE)

Institution \_\_\_\_\_

Complete Address \_\_\_\_\_

Type of Work \_\_\_\_\_

Dates: From \_\_\_\_\_ To \_\_\_\_\_

Institution \_\_\_\_\_

Complete Address \_\_\_\_\_

Type of Work \_\_\_\_\_

Dates: From \_\_\_\_\_ To \_\_\_\_\_

**INSTITUTIONAL AFFILIATIONS**

List in chronological order all institutional affiliations since completion of postgraduate education. This includes all hospitals, corporations, military assignments or government agencies.

Institution \_\_\_\_\_

Complete Address \_\_\_\_\_

Type of Appointment \_\_\_\_\_

Department Chairman \_\_\_\_\_

Dates: From \_\_\_\_\_ To \_\_\_\_\_

Institution \_\_\_\_\_

Complete Address \_\_\_\_\_

Type of Appointment \_\_\_\_\_

Department Chairman \_\_\_\_\_

Dates: From \_\_\_\_\_ To \_\_\_\_\_

Institution \_\_\_\_\_

Complete Address \_\_\_\_\_

Type of Appointment \_\_\_\_\_

Department Chairman \_\_\_\_\_

Dates: From \_\_\_\_\_ To \_\_\_\_\_

**Have your privileges at any hospital or any other health care facility been voluntarily or involuntarily limited, suspended, reduced or revoked, or are you presently under investigation? Yes \_\_\_ No \_\_\_**

**Has your Medical Staff membership at any hospital or other health care facility been voluntarily or involuntarily terminated? Yes \_\_\_\_\_ No \_\_\_\_\_**

Have you ever come before a committee of a hospital or peer review group for review involving a quality of care issue, or have you ever had your privileges suspended or restricted either voluntarily or involuntarily?

Yes \_\_\_\_\_ No \_\_\_\_\_

If the answer is yes to any question or if more space is needed to supply complete information, please provide a full explanation of the details on a separate sheet and attach.

**Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings in any professional organization? Yes \_\_\_\_\_ No \_\_\_\_\_**

If yes, please provide full explanation of the details on separate sheet and attach.

**PROFESSIONAL LIABILITY DATA/INSURANCE**

Present insurance carrier (Name and Complete Address)

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

Policy Number \_\_\_\_\_

Amount of Coverage \_\_\_\_\_

Expiration Date \_\_\_\_\_

**Does your policy cover clinical privileges sought in this application? Yes \_\_\_\_\_ No \_\_\_\_\_**

**Has your professional liability insurance coverage ever been terminated by action of the insurance company? Yes \_\_\_\_\_ No \_\_\_\_\_**

**Have you ever been denied professional liability insurance coverage? Yes \_\_\_\_\_ No \_\_\_\_\_**

Do you have a malpractice tail should you leave your current practice? Yes \_\_\_\_\_ No \_\_\_\_\_

If the answer to any question is yes, state when and by what company:

\_\_\_\_\_

**LEGAL ACTIONS**

Have any professional liability or professional misconduct suits or proceedings ever been brought against you? Yes \_\_\_\_\_ No \_\_\_\_\_

Have any professional liability suits ever been filed against you which are presently pending? Yes \_\_\_\_\_ No \_\_\_\_\_

Have any judgments or settlements been made against you in professional liability or professional misconduct matters? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have any current legal or other problems that would affect your practice of medicine or have you ever been convicted of any felony or crime involving moral turpitude? Yes \_\_\_\_\_ No \_\_\_\_\_

If the answer to any of the above questions is yes, please provide an explanation.

**HEALTH STATUS**

Appointment to the Medical Staff is a privilege that shall be extended only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in the Policy of the Medical Staff and are adopted from time to time by the Board of Trustees. Among these qualifications are the conditions of the applicant's physical health and mental and emotional stability.

Do you have any physical, mental or emotional condition that could affect the exercise of your clinical privileges, your provision of quality, safe patient care, or which might limit your ability to meet other duties associated with Medical Staff membership and which could require an accommodation for you to exercise your clinical privileges and Medical Staff duties completely and safely?

Yes \_\_\_\_\_ No \_\_\_\_\_

Have you in the past or are you currently having any problems with illegal substance abuse that would affect your practice of medicine? Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered yes to the question, please give a full explanation of the details on a separate sheet and attach. Included should be information regarding the name of any institution, organization or other entity at which accommodation was made for the condition. Include the name, address and telephone number of a knowledgeable person at the hospital, organization or other entity at which accommodations were made.

**CLINICAL ALTERNATE COVERAGE AND RESPONSE TIME**

As a condition of appointment, it is required that all members of the staff assume their share of the responsibility for emergency coverage at the hospital; and that each physician have one alternate staff member (**unless you are applying to the department of ob/gyn or surgery which requires two alternates**) listed who would assume his responsibilities if needed. Further, it is each individual physician's responsibility to notify his alternate, and appropriate hospital departments, when he will not be available.

Clinical Alternate (**must be on our staff**): \_\_\_\_\_

Clinical Alternate's Address: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

**PLEASE ATTACH COPIES OF:**

- Current Illinois State License and Controlled License
- Current Federal DEA License
- Certificates of Medical School, Internship, Residency and Fellowship.
- Certificate from Specialty Board or letter indicating admissibility to take examination.

**Please Note:** According to the Medical Staff Bylaws/Policy, Article II, Appointment to the Medical Staff - Part A: Section 2, Specific Qualifications:

Only physicians, dentists and podiatrists who satisfy the following conditions shall be qualified for appointment, and continued appointment if granted, to the Medical Staff: (e) are certified by the appropriate specialty board or are making active progress toward such certification...

- Copy of Malpractice Insurance Face Sheet indicating coverage of at least \$1 million/3 million and expiration date.
- Current Curriculum Vitae (CV)