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, 8th Floor
Baltimore, MD 21201
Telephone: (410) 328-2902
Fax: (410) 328-6433
Website: www.umm.edu/professionals/medstaff

UNIVERSITY of MARYLAND MEDICAL CENTER

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.

UNIVERSITY of MARYLAND
MARYLAND MEDICINE
COMPREHENSIVE INSURANCE PROGRAM

250 West Pratt Street
Suite 1200
Baltimore, MD 21201
410-328-4704 | 410-328-0568 FAX
www.mmcip.org

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

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

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.

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
Professional License				
Maryland License Number				
Additional Professional License				
Name of State/Country				
Additional Professional License				
Name of State/Country				
Additional Professional License				
Name of State/Country				
Other				
Name of State/Country				
Other				
Name of State/Country				
Other				
Name of State/Country				
Federal DEA				
Maryland CDS				
CPR BLS				
ACLS				
PALS				
NRP				
Medicaid Provider Number				
Tax ID Number				
NPI Number				

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_____

VII. SPECIALTY/BOARD CERTIFICATION STATUS *N/A* ☐

Specialty/subspecialty in which you are certified or recertified:	Year Certified	Year Recertified	Expiration Date

A. If you are not certified: YES NO
1. Do you intend to apply (or have you applied) for the certification exam? ☐ ☐
2. Have you ever taken the certification exam? ☐ ☐
3. Number of times you have taken the exam _____
4. Date your eligibility to take the examination expires/expired _____

Please explain any "NO" answers to questions A:

B. Have you been accepted to take the certification examination? ☐ ☐
If "YES," what date are you scheduled to take the exam? _____
(Please attach a copy of the letter from the Board indicating scheduled dates and/or your status in the process)

C. Please explain why certification does not apply to you:

VIII. PROFESSIONAL LIABILITY INSURANCE

YES NO

A. Are you presently covered by professional liability insurance? ☐ ☐

B. Have you been continuously covered since first obtaining professional liability insurance? ☐ ☐
Please explain any "NO" answers to questions A & B:

C. Are there any restrictions, limitations, or exclusions to your current professional liability coverage? ☐ ☐

D. Has your professional liability coverage (past or present) ever been denied, limited, reduced, interrupted, terminated, or not renewed by action of the insurance company? ☐ ☐
Please explain any "YES" answers to questions C & D:

E. Have you ever been, or are you currently, the subject of a professional liability suit, including malpractice claims? ☐ ☐

F. Have any judgments or settlements ever been paid on your behalf? ☐ ☐
Please explain any "YES" answers to questions E & F on page 9

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

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:

Your professional relationship with patient: ☐Attending ☐Consultant ☐Resident
☐ Other_____

Describe your clinical care in this case:

Current status of suit:

☐ Filed ☐ Deposed Settled in favor of: ☐ Plaintiff ☐ Defendant
☐ Settled out of court ☐ Awaiting trial
☐ Dismissed or withdrawn ☐ Other: please describe_____

Date of resolution:_____Amount of settlement (if applicable)_____

Name_____
Specialty_____

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	☐	☐
b. Any other professional registration or license	☐	☐
c. DEA/CDS Registration	☐	☐
d. Academic appointment	☐	☐
e. Membership on the staff of any facility, health plan, or HMO	☐	☐
f. Clinical privileges/rights on the staff of any facility, health plan, or HMO	☐	☐
g. Board certification	☐	☐
h. Medicare or Medicaid participation	☐	☐
i. Internship or residency program	☐	☐
j. Any research activities	☐	☐
k. Any other type of professional sanction (i.e., Quality Improvement Organization, CLIA, OSHA, etc.)	☐	☐
2. Have you ever resigned in order to avoid revocation, suspension, or reduction of privileges at any facility or institution?	☐	☐
3. Has information pertaining to you ever been reported to the National Practitioner Data Bank?	☐	☐
4. Have you ever been sanctioned or otherwise disciplined by a professional organization and/or licensing board for a violation of ethical standards?	☐	☐
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?	☐	☐
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?	☐	☐
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?	☐	☐
4. Are you engaged in the illegal use of drugs?	☐	☐
C. OTHER		
1. Have you ever been named a defendant in any criminal case, other than misdemeanor traffic violation?	☐	☐
2. Have you ever been convicted of, pled guilty to, or pled nolo contendre 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?	☐	☐
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?	☐	☐
4. Do you, alone or jointly, have ownership in any medical facility, medical services, or equipment to which you might refer patients?	☐	☐
5. Have you ever been convicted of a felony?	☐	☐

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.

	YES	NO
Have you met the CEU/CME requirements for maintaining your professional license?	☐	☐
Have you participated in CEUs/CMEs pertinent to your specialty?	☐	☐

If "NO" to either of above, please explain:

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:

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.

☐ American Indian or Alaskan native:
A person having origins in any of the original peoples of North, Central, or South America who maintains tribal affiliation or community attachment.

☐ Asian:
A person having origins in the Far East, Southeast Asia or the Indian sub-continent.

☐ Black or African American:
A person having origins in any of the original groups of Africa.

☐ Native Hawaiian or other Pacific Islander:
A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

☐ White:
A person having origins in any of the original peoples of Europe, North Africa, or the Middle East

UNIVERSITY of MARYLAND MEDICAL CENTER

110 South Paca Street, 8th 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 -revised 5/03

By applying for appointment to the medical staff of 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 appointment or cause for summary dismissal from the medical staff of the University of Maryland Medical System.

2. I agree that, if appointed, I will read and follow the Medical Staff Bylaws and the Rules and Regulations 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 Nonprocurment 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.

   *If I am a full-time or part-time member of the faculty of the School of Medicine who will provide billable services through a professional association under the Medical Service Plan, "others" includes third party payors with whom my professional association (and/or University Physicians, Inc. on behalf of my professional association) contracts, for the purpose of enabling these third party payors to accept me as a participating provider.

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 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 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 Medical System or only those privileges eventually approved by the Governing Board of the Medical System.

1. I understand that as a member of the Medical Staff, 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.

. PRACTITIONER PHOTO

Applicant's Signature: _____

Applicant's Name Printed: _____

Date: _____

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 extend 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: _____

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

www.umm.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

_____ _____
Date

Chair, Department of _____

Revised 9/2013