

Baltimore, MD 21201 Phone: (410) 328-2902 fax: (410) 328-6433

## RESIDENT/FELLOW CREDENTIALING APPLICATION

Instructions: Please read the following instructions carefully, as proper completion and submission of your application is essential for consideration of your appointment.

- 1. After reviewing the Frequently Asked Questions, please complete this application in full. Do not leave any items blank. **DO NOT USE WHITEOUT.** If a response is "no", "none", or "not applicable", please state. **If you make a mistake, cross out the error and <u>initial</u>**. Any material misstatements in, or omission from the application constitutes grounds for denial of appointment or for summary suspension without recourse.
- 2. Please type or print all responses.
- 3. For all requested addresses, please furnish complete street address, city, state, and zip code. Please include beeper, email and FAX numbers if applicable.
- 4. Use additional paper, if necessary, to supply complete responses.

5.	In addition to the completed application, the following documentation, if applicable, must be returned in order for your application to be processed*:			
	Current Curriculum Vitae;			
	Copy of Educational Commission for Foreign Medical Graduate Certificate(if applicable)			
	House Staff Association Sign Up Form (optional)			
	Copy of current Maryland license (if applicable);			
	Copy of Federal Drug Enforcement Administration (DEA) registration (if applicable);			
	Copy of Maryland CDS registration (if applicable);			
	Copy of Board Certification, if applicable;			
	Copy of all prior Malpractice Insurance Certificate(s) – not applicable if coming directly out of Medical/Professional School.			

6. Please return your application via First Class Postal Service. If necessary, please fax your application to 410.328.6433 and mail the original to our office.

**NOTE:** Health Assessment paperwork **should not be returned to this office**. Complete and keep this with you until your appointment with Employee Health.

# RESIDENT/FELLOW CREDENTIALING APPLICATION

	T 1: PERSONAL INFORMATION e (Last, First, Middle):			
	ous name that degree would be under:			
Degr	ee (MD, DDS, RN, etc.):		Gender: □ Male □ Female	
	of Birth:		Social Security Number:	
Place	e of Birth: City	State	Country	
Citiz	enship: USA by Birth	Other(specify)	Naturalized US Citize	n
Depa	ertment:		Subspecialty:	
Prim	ary Office Address:			
	ee Phone:		Office Fax:	
Offic	ee e-mail:			
Hom	e Address:			
Hom	e Phone:		Beeper:	
Hom	e e-mail:			
Prefe	erred Mailing Address: Office	Home		
DAD	T II: EDUCATION			
1.	Undergraduate (School name & complete a School Name			
	Dates Attended (MM/YY) From			
2.	Medical/Dental School (name & complete School Name			
	Mailing Address			
	Dates Attended (MM/YY) From			
3.	Other Graduate Education (Institution and School Name	<u>-</u>		
	Mailing Address			
	Dates Attended (MM/YY) From			
4.	If you are a foreign medical graduate, plea	se complete the follow	ing: (NOT APPLICABLE) Please attach copy.	
	ECFMG Number:	Date Passed:	Valid Until:	

	Institution			
	Program type (Specify):			
	□ Internship	☐ Residency	☐ Fellowship	☐ Specialty Training
	☐ Professional program	☐ Clinical	□ Research	☐ Other:
	Specialty		Dates Attended (MM/YY)	From to
	Program Director			
	Program Completed? □ Yes	□ No ( <b>If no, please provid</b>	le explanation on page 11)	
	Institution			
	Program type (Specify):			
	☐ Internship	☐ Residency	☐ Fellowship	☐ Specialty Training
	☐ Professional program	☐ Clinical	□ Research	☐ Other:
	Specialty		Dates Attended (MM/YY)	From to
	Program Director			
			· · · · · · · · · · · · · · · · · · ·	
	P1 /E /E :1			
	P1 /E /E :1			
	Phone/Fax/EmailProgram Completed? □ Yes	□ No (If no, please provid	e explanation on page 11)	
	Phone/Fax/EmailProgram Completed? □ Yes	□ No (If no, please provid		
:-	Phone/Fax/EmailProgram Completed? □ Yes	□ No (If no, please provid	e explanation on page 11)	
	Phone/Fax/EmailProgram Completed? □ Yes  Institution	□ No (If no, please provid	e explanation on page 11)	
	Phone/Fax/Email  Program Completed? □ Yes  Institution  Program type (Specify):	□ No ( <b>If no, please provid</b>	e explanation on page 11)	
	Phone/Fax/EmailProgram Completed? □ Yes  Institution  Program type (Specify): □ Internship □ Professional program	□ No ( <b>If no, please provid</b> □ Residency □ Clinical	e explanation on page 11)  □ Fellowship □ Research	☐ Specialty Training ☐ Other:
	Phone/Fax/Email Program Completed? □ Yes  Institution Program type (Specify): □ Internship □ Professional program  Specialty	□ No ( <b>If no, please provid</b> □ Residency □ Clinical	e explanation on page 11)  □ Fellowship □ Research	☐ Specialty Training ☐ Other: From to
	Phone/Fax/Email	□ No ( <b>If no, please provid</b> □ Residency □ Clinical	e explanation on page 11)  □ Fellowship □ Research □ Dates Attended (MM/YY)	☐ Specialty Training ☐ Other: From to
:-	Phone/Fax/Email Program Completed? □ Yes  Institution Program type (Specify): □ Internship □ Professional program Specialty Mailing Address Program Director	□ No ( <b>If no, please provid</b> □ Residency □ Clinical	e explanation on page 11)  □ Fellowship □ Research □ Dates Attended (MM/YY)	☐ Specialty Training ☐ Other: From to
-	Phone/Fax/Email Program Completed? □ Yes  Institution Program type (Specify): □ Internship □ Professional program Specialty Mailing Address Program Director	□ No ( <b>If no, please provid</b> □ Residency □ Clinical	e explanation on page 11)  □ Fellowship □ Research □ Dates Attended (MM/YY)	☐ Specialty Training ☐ Other: From to
	Phone/Fax/Email Program Completed? □ Yes  Institution Program type (Specify): □ Internship □ Professional program Specialty Mailing Address Program Director Phone/Fax/Email Program Completed? □ Yes	□ No (If no, please providency □ Clinical □ No (If no, please providence)	e explanation on page 11)    Fellowship   Research     Dates Attended (MM/YY)     e explanation on page 11)	☐ Specialty Training ☐ Other: From to
	Phone/Fax/Email Program Completed? □ Yes  Institution Program type (Specify): □ Internship □ Professional program Specialty Mailing Address Program Director Phone/Fax/Email Program Completed? □ Yes	□ No (If no, please providency □ Clinical □ No (If no, please providence)	e explanation on page 11)  □ Fellowship □ Research □ Dates Attended (MM/YY)	☐ Specialty Training ☐ Other: From to
II:	Phone/Fax/EmailProgram Completed? □ Yes  Institution  Program type (Specify): □ Internship □ Professional program  Specialty Mailing Address  Program Director Phone/Fax/Email Program Completed? □ Yes  PROFESSIONAL CAREER	□ No (If no, please provide □ Residency □ Clinical □ No (If no, please provide (Please account for all time	e explanation on page 11)    Fellowship   Research     Dates Attended (MM/YY)     e explanation on page 11)	☐ Specialty Training ☐ Other:  From to  ressional school graduation)
П:	Phone/Fax/Email	□ No (If no, please provide □ Residency □ Clinical □ No (If no, please provide (Please account for all time	e explanation on page 11)    Fellowship   Research     Dates Attended (MM/YY)    e explanation on page 11)   periods following medical/dental/professions	☐ Specialty Training ☐ Other:  From to  ressional school graduation)  PPLICABLE
П:	Phone/Fax/Email Program Completed? □ Yes  Institution Program type (Specify): □ Internship □ Professional program Specialty Mailing Address Program Director Phone/Fax/Email Program Completed? □ Yes  PROFESSIONAL CAREER  Hospital/Health Care Facilities In Facility Name	□ No (If no, please provide □ Residency □ Clinical □ No (If no, please provide (Please account for all time	e explanation on page 11)    Fellowship   Research     Dates Attended (MM/YY)     e explanation on page 11)   e periods following medical/dental/profent and prior affiliations. (NOT AF	☐ Specialty Training ☐ Other:  From to  ressional school graduation)  PPLICABLE

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

Name:

Name:					Date:		_
	L. P. III N.						
		22		Status of Privileges _			
		ce		Dates of Affiliation:			
	Supervisor's Ivani	e		Phone/Fax/Email			
	c. Facility Name						
	Street Address						
	City/State/Zip						
				Status of Privileges _			
	Department/Servi	ce		Dates of Affiliation:			
	Supervisor's Nam	e		Phone/Fax/Email			
2.	Military Duty	(NOT APPLI	CABLE	)		Type of	
		•			a :		
	<u>Date From</u>	<u>Date To</u>	Serial or Svc #	Branch of S	<u>Service</u>	Discharge*	
3.	you were not employe	began your professiona ed in medical practice? No ( <b>If yes, please prov</b> i	(more than three mont		ve there been a	ny gaps or periods in	which
PART 1	IV: MEDICAL/DENT	AL BOARD EXAMIN	NATIONS (Please ind	icate examinations passe	ed): (NOT APP	LICABLE)	
	NBME	Part I		Part II	Part II	I	
		Date		Date		Date	
	NBDE	Part I		Part II			
		Date		Date	_		
	USMLE	Part I		Part II	Part II	ī	
	CSMEE	Date	<del></del>	Date	_ ' ' ' ' ' ' '	Date	
	FLEX	Date					
	NBOME	Part I		Part II	Part II	I	
		Date		Date		Date	
PART V	V: LICENSES/REGIS	STRATIONS (ALL C	URRENT AND PRIC	<b>OR</b> ) (Please attach copie	es of all current	licenses to applicatio	n)
1. (	Current Maryland Medic	cal License Number:		Expiration Date:			
			OR				
1	Inlicensed Medical Pro	ctitioner (LIMP) Regist	ration Number (if curre	ntly/previously enrolled in	Maryland recider	ncy/fellowship)	

		n requirements for licensure on required if answered ''N	by all state Boards which you No")	are licensed?
ug Control (Contro	lled Substance) Regis	stration: (NOT A	PPLICABLE)	(Please attach copies to app
deral (DEA) Numb oust have Maryland a	er:ddress to be used in Mary	Expiration	on Date:	_
ate (CDS) Number		Expiration	on Date:	
ntional Provider Id equired)	lentifier (NPI) Num	ber *:	or Che	ck if NPI applied for:
: BOARD CERT	FICATION AND PI	ROFESSIONAL MEMBE	RSHIPS	
Board Certification Board Name	Status	Date <u>Certified</u>	Date <u>Recertified</u>	If Not Certified Eligible Until:
	AL LIABILITY CO			
Are you presently	covered by profession	al liability insurance?	YesNo	
Current Carrier:		me:		
	City		ate Zip	
Policy Number: Period of covers		m: To	· ·	
Limits of covera		iii. 10	) <b>.</b>	
Type of coverage		Claims Made	□Extended Reporting Policy	(Tail)
Please list all previ	ous professional liabil	lity carriers:*		
Previous Carrie	:: Nar	ne:		
		l Address		
D. I. N	City	y St	ate Zip	
		m: To	).	
Policy Number:		111.	).	
Period of covers				

Name	: Date:		_
3.	Malpractice History:		
J.		YES	NO
	a. Are any liability claims pending/under investigation against you?		
	b. Has any judgment been entered against you in any professional liability case?		
	c. Has any settlement been made in any professional liability case in which you or your insurance carrier had to or agreed to make monetary payment?		
	d. Have any professional liability claims been filed against you or have you reported any		
	malpractice claim to any insurance carrier?		
	e. Have you been notified or are you aware that a claim may be made against you?		
	f. Have you been denied professional liability insurance?		
	g. Has any professional liability insurer refused to renew your policy or placed limitations		
	on the scope of your coverage?		
:	***If any answer to questions 3a - 3e is yes, please provide full information on the Malpractice Claims/Suit History Adder  **If any answer to 3f or 3g is yes, please provide full information on page 11**	ndum (page 10)*	**
Either limited	VIII: VOLUNTARY, INVOLUNTARY, AND/OR PROFESSIONAL DISCIPLINARY ACTIONS: voluntarily or involuntarily, have any of the following ever been, or are currently being: withdrawn, relinquished, r. l, placed on probation, denied, revoked, suspended, or currently pending/under investigation: (If "Yes", please pro-		
on the	attached sheet of paper)		
		YES	NO
1.	Medical/Dental/Psychology license in any state		
2.	Other professional registration/license		
3.	DEA Certificate		
4.	Residency/Fellowship training		
5.	Academic appointment		
6.	Membership on any hospital medical staff		
7.	Clinical privileges, prerogative/rights on any medical staff		
8.	Board certification		
9.	Any other type of professional sanction (i.e. Peer Review Organization)		
10.	Have you resigned in order to avoid possible revocation, suspension or reduction of privileges at		
	any hospital or institution?		
PART	IX: CRIMINAL ACTIONS: (If "Yes", please provide a full explanation on the attached sheet of paper)	YES	NO
1.	Have there been or are there any criminal charges or convictions pending against you?	115	110
2.	Have you ever been convicted of a criminal offense?		
3.	Have you pled guilty, nolo contendere, been convicted, received probation before judgment or other		
υ.	diversionary disposition of any criminal act (excluding traffic violations)?		
4.	Have you pled guilty, nolo contendere, been convicted of, received probation before judgment or other		
	diversionary disposition for driving while intoxicated, or for a controlled dangerous substance offense?		
D.A. D.C.	W. HIDAT THE CIDATELES (TO HIV AND ALLES AND A		
PAKT	X: HEALTH STATUS: (If "Yes", please provide a full explanation on the attached sheet of paper)	YES	NO
1.	Do you have any physical/mental condition (including alcohol or drug dependence) that limits or	123	
	adversely affects your ability to participate fully in the care of your patients?		
2.	Have you been hospitalized, institutionalized, or involved in a patient treatment program that limited		
۷.	your ability to participate fully in the care of your patients?		
2			
3.	Are you presently, or have you within the last year, engaged in the use of illegal drugs?		

Name	e:	Date:		
PAR'	T XI: ADDITIONAL QUESTIONS: (If "Yes", pleas	se provide a full explanation on the attached sheet of paper)	TO I	v.O.
1. 2.	Have you been subject to sanctions as a Medicare or M Have you ever been the subject of a focused review by similar agency including but not limited to Medicare,	Medicaid provider? y a Peer Review Organization (PRO) or	ES I	NO 
3.	Do you have ownership in any medical facility or join equipment with a facility to which you might refer particularly.	nt ownership of any medical services, or		
4.	Have you been disciplined or counseled for engaging it	in harassment or discrimination on the		
5.	basis of race, creed, color, religion, gender, or sexual of Have you been the subject of an administrative, civil of regarding sexual misconduct or child abuse? (If "Yes" and court caption of any pending lawsuit on a separate	or criminal complaint or investigation ", provide full details including the plaintiff e piece of paper. Mark "Yes" if you have		_
	previously told us of the event but there has been active	vity or change. )		
PAR	T XII: PROFESSIONAL REFERENCES			
past f this a	five years. Please do not include as references individua	o have been in a position to judge or supervise your clinical performance als related by blood or marriage, training colleagues, or persons previous only use persons with the equivalent professional suffix as yours reference to improve processing time.	ously list	ted in
1)	Name and Title:			
	Address:			
2)	A 11			
	Address:			
	Phone/Fax/E-mail:			
3)	A 11			
	are to complete this application form in a timely mann mation shall, by itself, constitute a basis for the denia	ner, withholding of requested information, or providing false or m al of participation in the requested training program.	isleading	<b>;</b>
PAR	T XIII: ATTESTATION (to be signed by all ap	oplicants)		
By significant is true	gning below, I,e to the best of my knowledge.	attest that all information contained on th	is applica	ıtion
Signa	ature of Applicant	Date		

## CONDITIONS OF TRAINING AND CONSENT TO RELEASE OF INFORMATION

By applying for training privileges at 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 participation in the training programs of the University of Maryland Medical System.
- 2. I agree that, if appointed, I will follow the Policies and Procedures applicable to the medical staff, as they may be changed from time to time.
- 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).
- 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.
- 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 to 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 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.
- 10. I understand that as a-training participant, 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.

11.	I agree to allow the University of Maryland Medical Center to survey future employers for the purpose of assessing the quality of
	education that was provided to me.

Applicant's Signature:		
Applicant's Name Printed:	 Date:	

REVISED – 2/07

## \*FOR UNIVERSITY OF MARYLAND MEDICAL SYSTEM RESIDENTS/FELLOWS ONLY\*

MARYLAND MEDICINE COMPREHENSIVE INSURANCE PROGRAM SELF INSURANCE TRUST

#### Consent to Release Information

As a condition of consideration of my application for professional liability coverage through the Maryland Medicine Comprehensive Insurance Program Self-Insurance Trust (the TRUST). I hereby authorize the release of information regarding my claims and insurance history and related information to appropriate representative of the TRUST. 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 hereby release from all liability the TRUST, its employees, agents, officers, representatives, attorneys, participating entities, subsidiaries, successors or assign, or 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 provide information to the TRUST concerning my claims and insurance history and related information, including privileged and/or confidential information. I understand that such communications and any deliberations relating to this application shall be privileged and confidential in accordance with applicable law.

If I am granted coverage through the TRUST, I agree to abide by any existing conditions of coverage of the TRUST, and other applicable professional liability insurance policies as they currently exist or as amended from time to time, and otherwise comply fully with the Office of Risk Management and its scheduled programs including attendance of the mandatory Risk Management Orientation within the designated time period.

As a condition of coverage through the TRUST, I must personally report any known occurrence or circumstance which has the potential of becoming a liability claim against myself or the TRUST within 30 days of its occurrence, to the Office of Risk Management (410) 328-4704. Among circumstances to report are:

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

Failure to comply with these specific requirements could jeopardize my coverage and future participation in the Trust.

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

I have completed this application truthfully and understand that any decision by the TRUST to provide coverage to me will be based in part on this application. I promise to advise the TRUST immediately of any changes, which would alter my responses on the application. I agree to comply fully with the Conditions of Coverage of the TRUST and the rules, regulations and requirements of the Office of Risk Management, upon acceptance of my application.

Applicant Signature:	
Applicant Printed Name:	
Date:	

# MALPRACTICE CLAIMS/SUIT HISTORY

# (FAILURE TO DISCLOSE INFORMATION MAY RESULT IN REJECTION OF YOUR APPLICATION)

Please copy this addendum form for each additional claim/suit

Name of Claimant:		
Date of Incident:		
Date Lawsuit/Claim Filed:		
Name of Court and Case Number:		
Description:		
_		
Status of the Case: (with re	ference to you, specifically)	
	Pending Closed Without Payment	
	Pre-Trial Settlement (\$ )	
	Verdict for Defendant  Verdict for Plaintiff (\$	
<u> </u>	Verdict for Plaintiff (\$) Other ()	
What was/is your status:		
	Sole Defendant	
	Co-Defendant (with	_)
	Other:	_
Name and Policy # of Insurance Carrier:		

Nan			Date:
Unl Phy	licensed Medical Practitioner. We collect th	is ir ryla	and Board of Physicians for any individual applying as an information strictly for reporting purposes to the Board of ind license or are exempt from registering as an unlicensed in:
	nnicity/Race:  If-identification)		
Eth	anicity:		
□ *A j	•	□ · Cen	Not of Hispanic or Latino origin atral American, or other Spanish culture or origin, regardless of
Rac	ce:		
Ple	ase Note: Multiracial candidates may select all a	pplic	able 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.		Native Hawaiian or other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
	Asian: A person having origins in the Far East, Southeast Asia or the Indian sub-continent.		White: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East
	Black or African American: A person having origins in any of the original groups of Africa.		
Ple	ase use this space to provide any required expla	natio	ons.