UNIVERSITY OF MARYLAND MEDICAL CENTER
UNIVERSITY OF MARYLAND MEDICINE

Medical Staff Services

110 South Paca Street
8th Floor
Baltimore, MD 21201
Phone: (410) 328-2902
Fax: (410) 328-6433

Checklist for University of Maryland Medical Center Rotator Application

This checklist outlines the documents required for credentialing as a rotator with the University of Maryland Medical Center. All rotators must complete the credentialing process prior to beginning any clinical activity. **Please submit all documents in one package at least four weeks prior to your rotation**. Any missing documentation may delay the processing of the application. You will be notified of all missing documentation, and this documentation must be received one week prior to the start of the rotation.

Forms Needed:

- ☐ Rotator Application
- ☐ Unlicensed Medical Practitioner Form/ **$100.00 check made out to Medical Staff Services** (not applicable for those currently registered with the Maryland Board of Physicians as an Unlicensed medical practitioners, those who currently hold a Maryland license, or those in military training programs)
- ☐ Rotator Evaluation completed by the current program director

Documentation Needed:

- ☐ Current Curriculum Vitae
- ☐ Copy of primary source verification of medical school graduation from home institution or notarized copy of medical school diploma
- ☐ PPD results from within the past year; If PPD positive, results from your most recent chest x-ray
- ☐ Copy of ECFMG certificate (if international medical graduate)
- ☐ Letter verifying malpractice insurance coverage or insurance certificate
- ☐ NPI information: All UMMC rotators are required to have a NPI number. If the resident does not have an NPI, one must be obtained. An application can be completed online at https://nppes.cms.hhs.gov

For Current Participants in Maryland Graduate Medical Training Programs

- ☐ Copy of UMP form submitted to Maryland Board of Physicians or copy of roster from Board of Physicians confirming UMP registration

Please mail all documents to Medical Staff Services, 110 S. Paca St., 8th Floor, Baltimore, MD 21201. The paperwork can also be faxed to 410-328-6433 however; if you are required to submit an UMP application, please mail the original UMP to the aforementioned address. The Board of Physicians does not accept faxes and scans.

If you have any questions, please contact the appropriate the Medical Staff Coordinator at 410-328-2902. Thank you.

UNIVERSITY OF MARYLAND MEDICAL CENTER
VISITING RESIDENT/FELLOW APPLICATION FORM

PART I: PERSONAL INFORMATION

Name (Last, First, Middle): _____

Degree (MD, DDS, RN, etc.):_____ Gender: □ Male □ Female Date of Birth: _____

Social Security Number: _____ Previous name that degree would be under: _____

Dates of Rotation/Department: _____

Home Address: _____

_____

_____

Home Phone: _____ Beeper: _____ E-mail: _____

Citizenship: _____ USA by Birth _____ Other(specify)_____ _____ Naturalized US Citizen

PART II: EDUCATION

1. Medical/Dental School

School Name _____

Mailing Address _____

Dates Attended (MM/YY) From _____ To _____

If you are a foreign medical graduate, please complete the following:

ECFMG Number: _____ Date Passed: _____ Valid Until: _____

2. Current Residency/Fellowship Program

Institution Name_____

Program type (Specify):

☐ Internship ☐ Residency ☐ Fellowship ☐ Specialty Training

Specialty_____ Dates Attended (MM/YY) From _____ to _____

Mailing Address _____

Program Director _____

Phone/Fax/Email _____

Name: _____ Date: _____

3. Previous Residency/Fellowship Training Programs

Institution/Mailing Address	Residency/Fellowship	Specialty	Dates

PART III: PROFESSIONAL CAREER (Please account for all time periods following medical/dental/professional school graduation)

1. Hospital/Health Care Facilities Affiliations: List all present and prior affiliations. (NOT APPLICABLE_____)

Institution/Mailing Address	Specialty	Dates (From/To)

2. In the time since you began your professional career (post medical/professional school), have there been any gaps or periods in which you were not employed in medical practice? (more than three months)
_____ Yes _____ No **(If yes, please provide an explanation below)**

_____

_____

_____

PART IV: LICENSES/REGISTRATIONS (ALL CURRENT AND PRIOR) (Please attach copies of all current licenses to application)

1. Current Maryland Medical License Number: _____ Expiration Date:_____

OR

Unlicensed Medical Practitioner (UMP) Registration Number (if currently/previously enrolled in Maryland residency/fellowship): _____

2. Other Professional Licenses Held: Please list all professional licenses ever held (including Medical/Dental Licenses)

Type of License	State	Number	Issue Date	Expiration Date

3. NPI Number: _____

4. Name: _____ Date: _____

PART V: BOARD CERTIFICATION AND PROFESSIONAL MEMBERSHIPS

1.	Board Certification Status Board Name	Date Certified	Date Recertified	If Not Certified, Eligible Until:
	_____	_____	_____	_____
	_____	_____	_____	_____

PART VI: PROFESSIONAL LIABILITY COVERAGE

1.

Current Carrier:	Name:		
	Full Address		
	City	State	Zip
Policy Number:			
Period of coverage:	From:	To:	
Limits of coverage:			
Type of coverage:	☐Claims Made ☐Occurrence ☐Extended Reporting Policy (Tail)		

PART VII: ADDITIONAL QUESTIONS

Please attach an explanation for any yes answers.

		Yes	No
1.	Have you ever faced disciplinary action or been placed on probation during training?	____	____
2.	Have you ever resigned, been forced to resign, or been terminated from a training program?	____	____
3.	Have you ever resigned, been forced to resign or been terminated from any employment?	____	____
4.	Have you voluntarily or involuntarily relinquished or had and disciplinary action taken against any license or clinical privileges?	____	____
5.	Do you have any physical/mental condition (including alcohol or drug dependence) that limits or adversely affects your ability to participate fully in the care of your patients?	____	____
6.	Are there any pending malpractice actions or findings of professional misconduct against you?	____	____
7.	Have you pled guilty, nolo contendere, been convicted, received probation before judgment or other diversionary disposition of any criminal act?	____	____
8.	Are there any criminal charges or convictions pending against you?	____	____

Failure to complete this application form in a timely manner, withholding of requested information, or providing false or misleading information shall, by itself, constitute a basis for the denial of participation in the requested rotation.

PART XI: ATTESTATION (to be signed by all applicants)

By signing below, I, _____ attest that all information contained on this application is true to the best of my knowledge.

_____ _____

Signature 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.

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.

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 11/09