



**ADDENDUM TO MARYLAND HOSPITAL CREDENTIALING APPLICATION**

Applicant: \_\_\_\_\_

Staff Category:     Active    Active - without clinical privileges     Consulting     Allied Health  
                                  Telemedicine

Spouse's Name: \_\_\_\_\_  N/A

Your E-mail Address: \_\_\_\_\_

Practicing with whom? \_\_\_\_\_  Solo

Anticipated start date: \_\_\_\_\_

Preferred method of communication: **Please complete the enclosed Physician Contact sheet.**

The following CPR training is required if you are requesting the privileges noted. Please provide copies of certificates.

|                              |  |
|------------------------------|--|
| Sedation Administration      | BCLS   |
| Emergency Medicine           | ACLS, unless Board Cert. in Emergency Medicine, Critical Care, or Anesthesia |
| Pediatric Emergency Medicine | PALS   |
| Attend deliveries            | NRP  |

Liability Insurance History:

Please provide information covering the previous 10 years on page 8 of the Maryland Hospital Credentialing Application.

Professional References

One of your professional references **must** be your most recent Department Chairman (your training Program Director, or if training completed, the Dept. Chairman at the hospital where you are most active). Please enter this information on page 11 of the application. Do not list family members, relatives, or individuals with whom you plan to enter into a partner relationship.

Appropriate professional references:

- Recent Department Chairman or recent training Program Director (required)
- Peer Physician(s)
- Nursing Director or Manager with whom you have worked in the past 10 years
- OR technician, OR nurse, or CRNA with whom you have worked

References will be asked to attest to your current professional competence, clinical skills, ethical character, mental and physical health status, and ability to work with others. Non-peer references will be asked to attest to your ethical character, mental and physical health status, and ability to work with others. CalvertHealth Medical Center will check references at each hospital in which you have been granted privileges, past and current.



CalvertHealth Medical Center
100 Hospital Road
Prince Frederick, MD 20678

410.535.4000
301.855.1012
410.535.5630 TDD

CalvertHealthMedicine.org

Professional Back-up Coverage

List the name(s) and phone number(s) of the physicians(s) with appropriate clinical skills with whom you have entered into an arrangement that ensures 24-hour, 7-day a week back-up coverage for your patients when you are not available.

Physician(s) must be a current member of the Medical Staff of CalvertHealth Medical Center.

Name: \_\_\_\_\_

Name: \_\_\_\_\_

DIRECT OR INDIRECT INTEREST

Do you or a member of your immediate family have a direct or indirect ownership interest, significant financial interest or serve as a member on the board of directors or trustees, or otherwise have a leadership position or have significant control regarding any of the following:

Table with 3 columns: Entity Name, Yes, No. Rows include Hospital, Clinical Laboratory, Diagnostic or Testing Center, Surgery Center, Pharmaceutical Company, Medical Device Company, Medical Equipment/Supplies, Ancillary Health Services, and Other entity providing services in competition with CalvertHealth System.

If so, complete the following for each entity:

Name of Organization: \_\_\_\_\_

Address of Organization: \_\_\_\_\_

Type and Size of Organization: \_\_\_\_\_

Nature of Business Interest (whether ownership and/or compensation and if personal or immediate family member):

I affirm that in conjunction with the granting of privileges, I have read and will abide by the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Hospital and Medical Staff policies.

Signature of Applicant

Date