CalvertHealth Medical Center
100 Hospital Road
Prince Frederick, MD 20678

410.535.4000
301.855.1012
410.535.5630 TDD

CalvertHealthMedicine.org

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	BLS
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). **All other references must be current**. 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) Current
- Nursing Director or Manager
- 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.

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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:

	Yes	***No***
Hospital	( )	( )
Clinical Laboratory	( )	( )
Diagnostic or Testing Center	( )	( )
Surgery Center	( )	( )
Pharmaceutical Company	( )	( )
Medical Device Company	( )	( )
Medical Equipment/Supplies	( )	( )
Ancillary Health Services (Home Health, Hospice; Physical, Occupational or Speech Therapy; Durable Medical Equipment; Infusion Therapy; etc.	( )	( )
Other entity providing services in competition with CalvertHealth System, CalvertHealth Medical Center or subsidiaries	( )	( )

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