CalvertHealth Medical Center
Medical Staff Services
100 Hospital Road
Prince Frederick, MD 20678

410.535.8242 Phone
410.535.8243 Fax

CalvertHealthMedicine.org

Pre- Application

Potential Start Date: _____

Name: _____ Degree: _____

Maiden Name: _____

Group Practice Name: _____ Email:_____

DOB:_____ SSN#: _____ NPI:_____

Primary Office Address: _____

Phone (☐) _____ Fax (☐) _____

Home Address: _____

Home Phone : _____ Mobile :_____

1. Board Certified:
   a. Are you board certified? Yes ☐ No ☐ If yes, what specialty (ies)

   _____

   b. If no, do you meet the requirements for Board Eligibility as set by your specialty board?
   Yes ☐ No ☐
   c. Date of scheduled exam: _____

2. If you are currently in Residency or Fellowship – Date of Completion _____
   Specialty _____

3. I currently am licensed in Maryland: YES ☐ NO ☐
4. What is the level of your anticipated activity at CHMC?
   - Admissions _____
   - Outpatient Procedures _____
   - Inpatient Procedures _____
   - Consultations _____
   - Percentage of your total practice _____
   - Contracted Group Services _____

Explain why you are seeking privileges and /or membership at CHMC:

_____

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5. Will you establish an office location within 25 miles of CHMC?

Yes ☐ No ☐ If yes, where and when _____

6. If appointed to the Medical Staff, will you agree to participate in the emergency call rotations as determined by your Department/Section and to treat all patients referred to you during such coverage regardless of ability to pay? Yes ☐ No ☐

7. If practicing solo, please indicate a CHMC provider who has explicitly agreed to provide continuing coverage for your patients when you are not available:

_____

8. Military Experience:

a. Please indicate which branch of the military you served in: _____

b. Please indicate years of service in the military: _____

c. Have you had any tort action during your time in the military, been dishonorably discharged or imprisoned? Yes ☐ No ☐

If yes, please explain: _____

9. I attest that at this time I am not subject to:

- any complaint or initiated or final disciplinary or corrective action taken by any federal, state or local disciplinary agency, commission or medical society, CHMC or other healthcare organizations;
- any ongoing/continuing/in-progress review or investigation to deny, revoke, suspend, change, reduce, limit, place on probation, not renew or relinquish privileges at any other institution;
- any physical, mental or emotional limitation which adversely affects my ability, skill, attitude or judgment to practice within the scope of privileges for which I currently hold;
- professional liability insurance coverage that has been limited, revoked or not renewed.

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I _____hereby request consideration for membership to the Medical Staff of CalvertHealth Medical Center or its affiliates. I absolutely and unconditionally release from any and all liability all CalvertHealth Medical Center and CalvertHealth Medical Group representatives for their actions performed in good faith and without malice, in connection with providing, obtaining or reviewing information and evaluating or making recommendations concerning the applicant and the applicant's credentials.

Provider Signature _____ Date _____

FEES: Our pre-application fee is $ 100.
If you qualify for Medical Staff Privileges, this fee will be rolled into our $ 350 application fee.
Please issue a check to: **CalvertHealth Medical Center** & mail to the address in the header.