CalvertHealth Medical Center
100 Hospital Road
Prince Frederick, MD 20678

410.535.4000
301.855.1012
410.535.5630 TDD

CalvertHealthMedicine.org

NAME:_____ **DATE:**_____

MALPRACTICE CLAIM/LAWSUIT HISTORY

NOTE: FAILURE TO DISCLOSE INFORMATION MAY RESULT IN REJECTION OF YOUR APPLICATION IN ACCORDANCE WITH THE MEDICAL STAFF BYLAWS

Please copy this addendum form for each additional claim/lawsuit

Name of Claimant: _____

Date of Incident: _____

Date Lawsuit/Claim Filed: _____

Full Case Caption
Case Number: _____

Description: _____

_____

_____

_____

Status of the Case (with reference to you, specifically):

_____ Pending
_____ Closed Without Payment
_____ Pre-Trial Settlement ($_____)
_____ Verdict for Defendant
_____ Verdict for Plaintiff ($_____)
_____ Other (_____)

What was/is your status:

_____ Sole Defendant
_____ Co-Defendant (with _____)
_____ Other: _____

Name and Policy # of
Insurance Carrier: _____

❒ **No history of malpractice claims**

Signature: _____

PRACTITIONER ACKNOWLEDGEMENT AND AUTHORIZATION FOR RELEASE

CalvertHealth Medical Center Providers
OR
CalvertHealth Medical Group

My application for appointment or reappointment to the CalvertHealth Medical Center (CHMC) Medical Staff is contingent upon my obligation of the following:

1. I authorize CHMC representatives, including CalvertHealth Medical Group (CHMG) representatives, **if applicable**, to consult with others associated with the applicant and/or who may have information bearing on the applicant's competence and qualifications.

2. In consideration for appointment, I agree to abide by the terms of the CalvertHealth System and Medical Staff Bylaws, Rules, Regulations, Policies and Procedures in all matters relating to the consideration of the application and the exercise of Medical Staff Membership and clinical privileges.

3. I unconditionally and absolutely release from any and all liability all CHMC and CHMG 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. The term "CHMC representatives" as used in these bylaws include members of the Board of Trustees, all officers, employees, and agents of the Hospital, all members of the Medical Staff, and all officers of the Medical Staff, its departments and committees, having responsibility for collecting or evaluating information concerning my credentials or making recommendations or acting on any application for Medical Staff membership or clinical privileges.

4. I unconditionally and absolutely release from liability all individuals and organizations who provide, in good faith and without malice, information to Hospital representatives, including otherwise privileged or confidential information, relating to my ability, background, professional ethics, character, physical and mental health, emotional stability, and other matters relating to my qualifications for staff appointment and clinical privileges.

5. I unconditionally and absolutely authorize and consent to CHMC and CHMG representatives providing other hospitals, medical associations, licensing boards and other organizations concerned with provider performance and the quality, appropriateness, and efficiency of patient care with any information related to such matters which the Hospital may have concerning the applicant, and releases the Hospital and its representatives from all liability for providing such information.

6. I authorize CHMC and CHMG to release my National Provider Identifier (NPI) Number to individuals and organizations requiring the number for billing purposes.

7. If deemed necessary for required peer review, I agree to provide specific patient data related to the treatment of my patients treated or admitted to CalvertHealth Medical Center for care.

8. I acknowledge that the granting of Medical Staff membership and clinical privileges shall not signify employment by CalvertHealth Medical Center for any purpose and I shall at all times be an independent practitioner unless a separate employment relationship is established by contract with the hospital, above and beyond having medical staff membership and clinical privileges.

9. I agree to respond to all requests for information, explanation, or other, from any regulatory agency of county, state or federal government; the PRO, HMOs, PPOs, indemnity insurance and other third party payers promptly and in detail.

Please add Passport size photo quality picture here.

_____
PRINTED NAME

_____ _____
SIGNATURE DATE