FAITH REGIONAL HEALTH SERVICES
Pre-Application Request Form

Please attach copies of the following:
Curriculum Vitae
DEA Certificate
ECFMG Certificate, if applicable
Board Certification
Current delineation list of the privileges you hold at the facility where you presently practice
Proof of Immigration status, if applicable

____________________	____________________
Name	Specialty/Subspecialty
____________________	____________________
Primary Office Address	Office Telephone Number
____________________	____________________
Home Address	Telephone Number
____________________	____________________
Fax Number	E-mail Address

List every residency begun or completed. If more than one residency was begun or completed, please supply the same information on a separate sheet and attach.

Dates:____________________ (month/year) to ____________________ (month/year)

Institution: ____

Address: ____

Department Chief or Program Director: ________________________

Specialty: ____

Was the program successfully completed? Yes ___ No ___

Are you currently Board Certified? Yes ____ No ____ Board Eligible? Yes ____ No____

If so, which Board(s) ________________________________

List all past states in which you have been licensed. Please include license number. If more space is necessary, please attach a list.

State & License #: ____________________________ Dates: ___________________

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Please answer each of the following questions in full. If the answer to any question is yes, please provide a full explanation on a separate sheet and attach:

1. Have any disciplinary actions been initiated or are any pending against you by any state licensure board? Yes ______ No _______

2. Has your license to practice in any state ever been denied, limited, suspended, or revoked?
Yes ___ No ___

3. Have you ever been suspended, sanctioned or otherwise restricted from participation in any private, federal or state health insurance program (for example, Medicare, Medicaid)?
Yes ____ No _____

4. Have you ever been named as a defendant in any criminal proceeding?
Yes ____ No _____

5. Have you ever had any problems with alcohol or drug dependency? Yes _____ No _______

6. Has your employment or medical staff appointment or privileges ever been suspended, diminished, revoked or refused at any hospital or other health care facility? Yes _______ No __

7. Have you ever withdrawn your application for appointment, reappointment or request for clinical privileges or resigned from the medical staff before a decision about your appointment and/or clinical privileges was rendered by a hospital's or health care facility's governing board?
Yes__ No _______

8. Have you ever been the subject of disciplinary proceedings at any hospital or health care facility? Yes ______ No _______

9. Have you ever been denied professional liability insurance coverage? Yes ___ No _______

10. Have any professional liability suits been filed against you, or are any pending?
Yes __ No ______

Please provide names, addresses, and telephone numbers of at least three individuals that you have recently worked with, at least one of whom is a peer. Requests for confidentiality will be honored as long as three recent co-workers/supervisors may be contacted.

1. Name: ____________________

   Address: ____________________

   City: ____________ State: ________ Zip: ______

   Telephone: ____________

2. Name: ____________________

   Address: ____________________

   City: ____________ State: ________ Zip: ______

   Telephone: ____________

3. Name: ____________________

   Address: ____________________

   City: ____________ State: ________ Zip: ______

   Telephone: ____________

Authorization Statement:

I hereby release from any liability any and all individuals and organizations who provide information to the Hospital, or the Credentials Committee, in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for Staff appointment and clinical privileges and I hereby consent to the release of such information.

The above information is true and accurate to the best of my knowledge and no known misrepresentations have been made.

______________________________________ ____________________

Signature Date