Name_____
Specialty_____

STATE OF MARYLAND
DHMH

MARYLAND HOSPITAL CREDENTIALING APPLICATION

Please type or print.
Incomplete or illegible applications will not be processed.

I. PERSONAL INFORMATION

Name (Last, First, Middle) _____

List any other names used _____

When was name changed?_____For what reason?_____

_____

SS# _____Date of birth (MM/DD/YYYY)_____

Place of birth: City_____State_____Country_____

Gender ☐ M ☐ F U.S. Citizen? ☐ Yes ☐ No

If not, immigration status & Visa number _____

Country of Citizenship_____

Languages spoken other than English_____

Professional degree(s) _____

Home address _____

City _____State_____Zip_____

Home phone number _____ Cell phone_____

E-mail_____

Preferred mailing address (check one):	☐ Home	☐ Primary office	☐ Office 2
Preferred E-mailing address (check one):	☐ Home	☐ Primary office	☐ Office 2
Preferred phone number (check one):	☐ Cell	☐ Primary office	☐ Office 2

II. CURRENT OFFICE INFORMATION

Copy this page as often as necessary to provide information on all office locations for this appointment.

PRIMARY OFFICE

Group or practice name_____

Street address _____

_____

City _____State_____Zip code_____

Office phone(s) _____ _____ _____

Office E-mail _____ Office fax_____

Web Site_____

Dates at this practice: From (MM/YYYY)_____ To: Present

Please complete if you have additional offices.

OFFICE 2

Group or practice name_____

Street address _____

_____

City _____State_____Zip code_____

Office phone(s) _____ _____ _____

Office E-mail _____ Office fax_____

Web Site_____

Dates at this practice: From (MM/YYYY)_____ To: Present

OFFICE 3

Group or practice name_____

Street address _____

_____

City _____State_____Zip code_____

Office phone(s) _____ _____ _____

Office E-mail _____ Office fax_____

Web Site_____

Dates at this practice: From (MM/YYYY)_____ To: Present

III. EDUCATION AND TRAINING

Please copy this page as needed to provide a complete record of all education and training.

A. PROFESSIONAL AND/OR MEDICAL EDUCATION

1. School name (if changed, list current name as well as name when you attended)

_____

Degree awarded _____Date(MM/YYYY) _____Program type_____

Complete mailing address_____

_____

City_____State/Country_____

Zip/Postal Code_____Dates attended: (MM/YYYY) From _____ to _____

Phone no._____Fax_____ E-mail_____

2. School name (if changed, list current name as well as name when you attended)

_____

Degree awarded _____Date(MM/YYYY) _____Program type_____

Complete mailing address_____

_____

City_____State/Country_____

Zip/Postal Code_____Dates attended: (MM/YYYY) From _____ to _____

Phone no._____Fax_____ E-mail_____

Are you ECFMG certified? ☐ Yes ☐ No Number:_____Date_____

B. GRADUATE OR POST GRADUATE TRAINING

Institution name (if changed, list current name as well as name when you attended)

_____

Specialty _____ Was this program ACGME accredited? ☐ Yes ☐ No

Program type (Specify):

☐ Internship ☐ Residency ☐ Fellowship ☐ Specialty Training

☐ Professional program ☐ Clinical ☐ Research ☐ Other:

Complete mailing address_____

_____

City_____State/Country_____

Zip/Postal Code_____Dates attended: (MM/YYYY) From _____ to _____

Program director name & title_____

Phone no._____Fax_____ E-mail_____

If you did not complete any listed program, please provide full details on a separate sheet of paper.

Institution name (if changed, list current name as well as name when you attended)

_____

Specialty _____ Was this program ACGME accredited? [ ]Yes [ ] No

Program type (Specify):

☐ Internship ☐ Residency ☐ Fellowship ☐ Specialty Training

☐ Professional program ☐ Clinical ☐ Research ☐ Other:

Complete mailing address_____

_____

City_____State/Country_____

Zip/Postal Code_____Dates attended: (MM/YYYY) From _____ to _____

Program director name & title_____

Phone no._____Fax_____ E-mail_____

Institution name (if changed, list current name as well as name when you attended)

_____

Specialty _____ Was this program ACGME accredited? [ ]Yes [ ] No

Program type (Specify):

☐ Internship ☐ Residency ☐ Fellowship ☐ Specialty Training

☐ Professional program ☐ Clinical ☐ Research ☐ Other:

Complete mailing address_____

_____

City_____State/Country_____

Zip/Postal Code_____Dates attended: (MM/YYYY) From _____ to _____

Program director name & title_____

Phone no._____Fax_____ E-mail_____

C. OTHER PROFESSIONAL PROGRAM

Institution name (if changed, list current name as well as name when you attended)

_____

Specialty _____ Was this program ACGME accredited? [ ]Yes [ ] No

Program type (Specify):

☐ Internship ☐ Residency ☐ Fellowship ☐ Specialty Training

☐ Professional program ☐ Clinical ☐ Research ☐ Other:

Complete mailing address_____

_____

City_____State/Country_____

Zip/Postal Code_____Dates attended: (MM/YYYY) From _____ to _____

Program director name & title_____

Phone no._____Fax_____ E-mail_____

***If you did not complete any of the programs listed, please provide full details on a separate sheet of paper*.**

Name________________________
Specialty______________________

IV. Affiliations, Privileges, and Employment

- **ACCOUNT FOR ALL TIME PERIODS, IN CHRONOLOGICAL ORDER, SINCE COMPLETION OF YOUR PROFESSIONAL EDUCATION. LIST ALL HEALTHCARE FACILITIES AT WHICH YOU HOLD, OR HAVE HELD PRIVILEGES. INCLUDE ANY MOONLIGHTING OR *LOCUM TENENS* WORK.**
- **ATTACHING A RÉSUMÉ OR CV IS NOT A SUBSTITUTE FOR COMPLETING THIS SECTION.**
- **PLEASE COPY THIS PAGE AS NECESSARY FOR ADDITIONAL ENTRIES.**

Dates: (MM/YYYY) From________________________To_________________________________
Organization/Facility name (if changed, list current name as well as former name)
____
Complete address____
____
City__________________________________State/Country________________________________
Zip/Postal Code__________________
Staff category or status of privileges____________________Department_______________________
Department chair/contact person name & title____
Phone___________________Fax______________________E-mail__________________________
Description of duties____
____
Reason for leaving____

Dates: (MM/YYYY) From________________________To_________________________________
Organization/Facility name (if changed, list current name as well as former name)
____
Complete address____
____
City__________________________________State/Country________________________________
Zip/Postal Code__________________
Staff category or status of privileges____________________Department_______________________
Department chair/contact person name & title____
Phone___________________Fax______________________E-mail__________________________
Description of duties____
____
Reason for leaving____

Dates: (MM/YYYY) From___________________________To______________________________
Organization/Facility name (if changed, list current name as well as former name)
____
Complete address____
____
City__________________________________State/Country________________________________
Zip/Postal Code__________________
Staff category or status of privileges____________________Department_______________________
Department chair/contact person name & title____
Phone___________________Fax______________________E-mail__________________________
Description of duties____
____
Reason for leaving____

Explain any gaps of one month or more on a separate sheet of paper.

Name_____
Specialty_____

V. PROFESSIONAL LICENSURE/ REGISTRATIONS/ CERTIFICATIONS

List all professional licenses ever held

Licensure/ Registrations/ Certifications	Type	✓ here if N/A	Number	Expiration Date
Professional License				
Maryland License Number				
Additional Professional License				
Name of State/Country				
Additional Professional License				
Name of State/Country				
Additional Professional License				
Name of State/Country				
Other				
Name of State/Country				
Other				
Name of State/Country				
Other				
Name of State/Country				
Federal DEA				
Maryland CDS				
CPR BLS				
ACLS				
PALS				
NRP				
Medicaid Provider Number				
Tax ID Number				
NPI Number				

Attach a copy of each document you maintain.

VI. U.S. MILITARY SERVICE ☐ YES ☐ NO

Dates: (MM/YYYY) From_____To_____

Current status:_____

Highest rank: _____

Branch:_____

Name_____
Specialty_____

VII. SPECIALTY/BOARD CERTIFICATION STATUS *N/A* ☐

Specialty/subspecialty in which you are certified or recertified:	Year Certified	Year Recertified	Expiration Date

A. If you are not certified: YES NO
1. Do you intend to apply (or have you applied) for the certification exam? ☐ ☐
2. Have you ever taken the certification exam? ☐ ☐
3. Number of times you have taken the exam _____
4. Date your eligibility to take the examination expires/expired _____

Please explain any "NO" answers to questions A:

B. Have you been accepted to take the certification examination? ☐ ☐
If "YES," what date are you scheduled to take the exam? _____
(Please attach a copy of the letter from the Board indicating scheduled dates and/or your status in the process)

C. Please explain why certification does not apply to you:

VIII. PROFESSIONAL LIABILITY INSURANCE

YES NO

A. Are you presently covered by professional liability insurance? ☐ ☐

B. Have you been continuously covered since first obtaining professional liability insurance? ☐ ☐
Please explain any "NO" answers to questions A & B:

C. Are there any restrictions, limitations, or exclusions to your current professional liability coverage? ☐ ☐

D. Has your professional liability coverage (past or present) ever been denied, limited, reduced, interrupted, terminated, or not renewed by action of the insurance company? ☐ ☐
Please explain any "YES" answers to questions C & D:

E. Have you ever been, or are you currently, the subject of a professional liability suit, including malpractice claims? ☐ ☐

F. Have any judgments or settlements ever been paid on your behalf? ☐ ☐
Please explain any "YES" answers to questions E & F on page 9

Name___________________________
Specialty_______________________

G. Professional Liability Carrier(s):

- **Please provide the following information for each professional liability carrier you have had in the past five years. The hospital to which you are applying may require more than five years of liability coverage history. Refer to the hospital-specific instructions that came with this application.**
- **Include any coverage maintained during training programs if within the past five years. If more space is required, please copy this page.**
- **Please explain any gaps or periods when you were without professional liability coverage on a separate sheet of paper.**

Provide a legible, clear copy of the face sheet from all available professional liability carriers.

Current Carrier:	Name:		
	Full Address		
	City	State	Zip
	Phone Number		Fax
Policy Number:			
Period of coverage:	From:	To:	
Limits of coverage:			
Type of coverage:	☐Claims Made ☐Occurrence	☐Extended Reporting Policy (Tail)	

Previous Carrier:	Name:		
	Full Address		
	City	State	Zip
	Phone Number		Fax
Policy Number:			
Period of coverage:	From:	To:	
Limits of coverage:			
Type of coverage:	☐Claims Made ☐Occurrence	☐Extended Reporting Policy (Tail)	

Previous Carrier:	Name:		
	Full Address		
	City	State	Zip
	Phone Number		Fax
Policy Number:			
Period of coverage:	From:	To:	
Limits of coverage:			
Type of coverage:	☐Claims Made ☐Occurrence	☐Extended Reporting Policy (Tail)	

Previous Carrier:	Name:		
	Full Address		
	City	State	Zip
	Phone Number		Fax
Policy Number:			
Period of coverage:	From:	To:	
Limits of coverage:			
Type of coverage:	☐Claims Made ☐Occurrence	☐Extended Reporting Policy (Tail)	

Previous Carrier:	Name:		
	Full Address		
	City	State	Zip
	Phone Number		Fax
Policy Number:			
Period of coverage:	From:	To:	
Limits of coverage:			
Type of coverage:	☐Claims Made ☐Occurrence	☐Extended Reporting Policy (Tail)	

H. CLAIMS HISTORY: **N/A** ☐

- **COMPLETE THE FOLLOWING INFORMATION AS IT PERTAINS TO YOUR PROFESSIONAL LIABILITY AND CLAIMS HISTORY.**
- **PROVIDE INFORMATION ON ANY AND ALL PROFESSIONAL LIABILITY SUITS IN WHICH YOU WERE NAMED, REGARDLESS OF THE OUTCOME. YOU MAY INCLUDE LEGAL DOCUMENTATION.**
- **IF MORE SPACE IS REQUIRED, PLEASE COPY THIS PAGE BEFORE COMPLETING.**

Date of alleged incident_____

Plaintiff(s)_____Patient's Name_____
State/Country in which suit was initiated_____ Date_____
Health Care Alternative Dispute Resolution or Court case number_____
Insurance carrier and address_____
_____
You were: ☐Primary defendant ☐Co-defendant

Description of allegation or complaint:

Your professional relationship with patient: ☐Attending ☐Consultant ☐Resident
☐ Other_____

Describe your clinical care in this case:

Current status of suit:

☐ Filed ☐ Deposed Settled in favor of: ☐ Plaintiff ☐ Defendant
☐ Settled out of court ☐ Awaiting trial
☐ Dismissed or withdrawn ☐ Other: please describe_____

Date of resolution:_____Amount of settlement (if applicable)_____

Name_____
Specialty_____

IX. ADDITIONAL QUESTIONS

All affirmative answers must be fully explained on a separate sheet of paper.

A. PROFESSIONAL ACTIONS:	YES	NO
1. Have any of the following ever been, or are in the process of being, voluntarily or involuntarily withdrawn, relinquished, not renewed, reduced, limited, placed on probation, denied, revoked, suspended, or investigated:		
a. Any professional license in any state or jurisdiction	☐	☐
b. Any other professional registration or license	☐	☐
c. DEA/CDS Registration	☐	☐
d. Academic appointment	☐	☐
e. Membership on the staff of any facility, health plan, or HMO	☐	☐
f. Clinical privileges/rights on the staff of any facility, health plan, or HMO	☐	☐
g. Board certification	☐	☐
h. Medicare or Medicaid participation	☐	☐
i. Internship or residency program	☐	☐
j. Any research activities	☐	☐
k. Any other type of professional sanction (i.e., Quality Improvement Organization, CLIA, OSHA, etc.)	☐	☐
2. Have you ever resigned in order to avoid revocation, suspension, or reduction of privileges at any facility or institution?	☐	☐
3. Has information pertaining to you ever been reported to the National Practitioner Data Bank?	☐	☐
4. Have you ever been sanctioned or otherwise disciplined by a professional organization and/or licensing board for a violation of ethical standards?	☐	☐
B. HEALTH STATUS NOTE: TJC REQUIRES CONFIRMATION OF THE APPLICANT'S HEALTH STATUS		
1. Do you have, or have you ever had, any physical or mental condition (including drug or alcohol abuse) that currently limits or adversely affects your ability to fully participate in the care of your patients?	☐	☐
2. Have you ever been hospitalized, institutionalized, or involved in a treatment program that currently limits your ability to fully participate in the care of your patients?	☐	☐
1&2: If such an impairment exists, please provide a description (on a separate sheet of paper) to include associated limitations and any accommodation(s) that would enable you to perform your duties consistent with accepted standards of practice.		
3. Have you ever been sanctioned, reprimanded or otherwise disciplined in any manner by any state licensing authority or other professional board or peer committee for conduct related to the use of alcohol or the use of drugs?	☐	☐
4. Are you engaged in the illegal use of drugs?	☐	☐
C. OTHER		
1. Have you ever been named a defendant in any criminal case, other than misdemeanor traffic violation?	☐	☐
2. Have you ever been convicted of, pled guilty to, or pled nolo contendre to, any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse, or a sexual offense or misconduct?	☐	☐
3. Have you ever been disciplined or counseled for engaging in harassment or discrimination on the basis of race, creed, religion, gender, or sexual orientation?	☐	☐
4. Do you, alone or jointly, have ownership in any medical facility, medical services, or equipment to which you might refer patients?	☐	☐
5. Have you ever been convicted of a felony?	☐	☐

X. CONTINUING EDUCATION

The hospital to which you are applying may require detailed information regarding this section. Refer to the hospital-specific instructions that came with this application.

	YES	NO
Have you met the CEU/CME requirements for maintaining your professional license?	☐	☐
Have you participated in CEUs/CMEs pertinent to your specialty?	☐	☐

If "NO" to either of above, please explain:

XI. PROFESSIONAL REFERENCES

- **LIST ONLY THOSE WHO CAN SPEAK TO YOUR CLINICAL COMPETENCE**

Each hospital has its own requirements for this section. Refer to the hospital-specific instructions that came with this application. Please note: TJC requires peer references for all credentialed practitioners.

Name:
Title: Supervisor ☐ Peer ☐
Mailing address:

City: State/Country: Zip/Postal Code:
Phone: Fax: E-mail:

Name:
Title: Supervisor ☐ Peer ☐
Mailing address:

City: State/Country: Zip/Postal Code:
Phone: Fax: E-mail:

Name:
Title: Supervisor ☐ Peer ☐
Mailing address:

City: State/Country: Zip/Postal Code:
Phone: Fax: E-mail:

Name:
Title: Supervisor ☐ Peer ☐
Mailing address:

City: State/Country: Zip/Postal Code:
Phone: Fax: E-mail:

XII. AFFIRMATION

I hereby attest and affirm that the information contained in this application is current, correct, and complete to the best of my knowledge. I affirm that I have read the hospital bylaws and rules and regulations of the medical staff and I agree to abide by those guidelines as they presently exist or as periodically amended. I understand that willful falsification or omission of information will be grounds for rejection or termination. I understand that this application is not complete unless a signed hospital-specific attestation is attached.

Name (Print)_____

Signature_____

Date:_____

Note: Sign and date this page within 10 days of submitting application.

XIII. STATISTICAL INFORMATION

The following information is supplied voluntarily and will be used only for statistical and governmental reporting requirements. Information contained in this section will not be used in any way to make decisions about an applicant's qualification for credentialing.

ETHNICITY/RACE: _____
(Self-identification)

ETHNICITY:

☐ Of Hispanic or Latino origin ☐ Not of Hispanic or Latino origin
A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Race:

Please Note: Multiracial candidates may select all applicable racial categories.

☐ American Indian or Alaskan native:
A person having origins in any of the original peoples of North, Central, or South America who maintains tribal affiliation or community attachment.

☐ Asian:
A person having origins in the Far East, Southeast Asia or the Indian sub-continent.

☐ Black or African American:
A person having origins in any of the original groups of Africa.

☐ Native Hawaiian or other Pacific Islander:
A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

☐ White:
A person having origins in any of the original peoples of Europe, North Africa, or the Middle East