Saint Clare's Health

MEDICAL STAFF
PRE-APPLICATION FORM

Date:

Name in Full: _____

☐MD, ☐DO, ☐DPM, ☐DMD, ☐PA, ☐PA-C, ☐NP, ☐APN, ☐RNFA

☐Other

Please send application to my: ☐ Practice Address ☐Residence Address

Practice Name _____

Practice Address _____

_____

Phone Number _____ Cell Number

Residence Address: _____

_____ Residence Phone Number _____

Email Address:

Department: _____ Subspecialty:_____

1. BOARD CERTIFICATION STATUS

1.1 Are you Board Certified in the specialty you anticipate practicing? ☐Yes ☐No

1.2 If yes, name of Board _____

1.3 If no, have you taken the requisite amount of training to classify you as being qualified to take the boards in your specialty and are you eligible to take the Boards now?

☐Yes ☐No

1.4 If no, when will you have completed your training and be eligible to take your Boards?

1.5 Do you plan to take the Board certification examination? ☐ Yes ☐ No

1.6 When do you plan to take the examination? _____

2. LOCATION OF PRACTICE

2.1 Do you plan to establish or have you established an office? ☐ Yes ☐ No

Where: _____

_____

2.2 When will office hours begin at the location? _____

3. HOSPITAL AFFILIATION

3.1 Are you planning to apply for appointment and clinical privileges or do you hold Privileges at any other hospital? ☐ Yes ☐ No

If yes, where? _____

3.2 What percentage of your total hospital practice do you anticipate using the facilities at Saint Clare's Hospital? _____

I request an application for appointment to the Medical Staff of Saint Clare's Hospital.

Signature: _____

Date: _____

Please fax back to 973-625-6457