Samaritan Regional Health System
1025 Center Street
Ashland, Ohio 44805
www.samaritanhospital.org
Danny L. Boggs, CHE, President/CEO

Request for Application

Instructions to candidate: This form must be completed in order to proceed with the application process. Return the completed form by email (kschroeder@samaritanhospital.org) or fax (419-207-2629).

1. Answer each question. Non-responses and a failure to provide explanations when asked will disqualify your application for processing.
2. If there are any time gaps in your education, training, or work experience (except for illness or vacation), you are required to provide a complete explanation.
3. The Credentials Committee chair will evaluate this form to determine your ability to meet the application requirements.
4. Failure to meet the Request for Application criteria may constitute your ineligibility to apply for membership and privileges.

Date: _____

Name in Full: _____

Any Other Name Used: _____

Office Address: _____

Office Telephone: _____ **FAX No.** _____

Residence Address: _____

Residence Telephone: _____ **FAX No.** _____

Email Address: _____

Birth Date and Place: _____ **Social Security No.** _____

Citizenship: _____

If not a citizen of the United States, please indicate the status of your visa at the present time.

(1) Please indicate your clinical specialty as well as any areas in which you may wish to request clinical privileges.

SPECIALTY

- ❑ Allergy & Immunology
- ❑ Anesthesiology
- ❑ Cardiology
- ❑ Diagnostic Radiology
- ❑ Family Practice
- ❑ Emergency
- ❑ Gastroenterology
- ❑ General Surgery
- ❑ Hematology
- ❑ Hospitalist
- ❑ Infectious Diseases
- ❑ Internal Medicine
- ❑ Medical Oncology
- ❑ Neonatology
- ❑ Neurology
- ❑ Obstetrics/Gynecology
- ❑ Ophthalmology
- ❑ Oral & Maxillofacial Surgery
- ❑ Orthodontics
- ❑ Orthopedics
- ❑ Otolaryngology
- ❑ Pain Medicine
- ❑ Pathology
- ❑ Pediatrics
- ❑ Physical Medicine & Rehabilitation
- ❑ Plastic & Reconstructive Surgery
- ❑ Podiatry
- ❑ Psychiatry
- ❑ Pulmonary Medicine
- ❑ Radiation Oncology
- ❑ Radiology
- ❑ Rheumatology
- ❑ Urology
- ❑ Vascular Surgery
- ❑ Other: _____

(2) I expect to assist the system in fulfilling its mission by:

- ❑ Admitting my patients in need of acute care services to the system for required hospital care
- ❑ Scheduling and performing surgery/procedures within the system
- ❑ Referring patients to the system for definitive consultation, work-up, and management

If you will not care for or refer patients within the system, how will you be assisting the system in its patient care mission? _____

_____

(3) In chronological order, please list all hospitals at which you have held clinical privileges during the last five years.

HOSPITAL	ADDRESS	DATES

Are you planning to apply for hospital privileges at Samaritan Regional Health System? ❑ **Yes** ❑ **No**

If yes, list requested privileges: _____

_____

Are you planning to apply for appointment and clinical privileges at any other hospital? ❑ **Yes** ❑ **No**

If yes, please list Hospital: _____

Address: _____

(4) ❑ **I am** ❑ **am not employed by a direct competitor of the system (i.e., a hospital or related corporation located within 20 miles of the system).**

❑ **I do** ❑ **do not own interest in a surgicenter, diagnostic facility, or other inpatient facility that competes directly with patients within the primary or secondary service area of the system.**

Yes	No	Question *Attach explanations when indicated
❑	❑	I have successfully completed a residency program approved by the Accreditation Council on Graduate Medical Education.
❑	❑	I hold a current Ohio license to practice medicine, osteopathy, dentistry, podiatry, or as na advanced practice nurse or physician assistant, or other applicable licensure, registration, or certification.
❑	❑	I am currently insured with medical malpractice insurance of at least $1 million/claim.
❑	❑	I currently have medical malpractice claims against me (pending, current, or settled).*
❑	❑	I have had my privileges restricted, suspended, reviled or denied in any healthcare institution, association, regulatory body, society, board, etc. *
❑	❑	I have withdrawn an application for staff membership or privileges because of an impending investigation.*
❑	❑	I have been named in a work environment harassment complaint.*
❑	❑	I have been convicted of a felony or misdemeanor (other than a simple traffic violation).*
❑	❑	I am Board Certified (if residency was completed after 2006).
❑	❑	I attest that there are no gaps in my education, training, or work history except for vacations or short term illnesses.*
❑	❑	I attest to abiding by the ethics of my profession as evidenced by a positive professional history that is free of acts of omission that constitute unprofessional conduct.*
❑	❑	I can provide documentation of the following as evidence of my current competence in support of my application and request for privileges: Education, Training, Knowledge, Experience, Judgment, Technique, and Ability to perform

(5) This form must be returned with copies of the following documents:

a. Current license(s) to practice medicine;

b. DEA License (DEA optional for Pathology privileges);

c. Professional liability insurance policy and certificate of coverage from insurance carrier;

d. ECFMG certificate (if foreign medical graduate);

e. Evidence of board certification status;

f. Copy of State Drivers Licenses;

g. A curriculum vitae;

h. $50 deposit fee.

I attest that all of the above information is accurate and complete. I request an application for appointment to the Medical Staff of Samaritan Regional Health System.

_____ _____

Signature **Date**

_____

Printed Name