

**VALLEY REGIONAL MEDICAL CENTER
PRE-APPLICATION QUESTIONNAIRE FOR MEDICAL STAFF APPLICATION**

Practitioners desiring a Medical Staff Application must complete this form in its entirety. Incomplete requests will be returned. It is important that this form be completed by the requesting practitioner to ensure accuracy.

1. Full Name: _____ Degree: _____

Office Address: _____

City: _____ State: _____ Zip: _____

Phone: ____ (____) _____

2. Current Home Address: _____

City: _____ State: _____ Zip: _____

Phone: ____ (____) _____

3. Date of Birth: _____ Sex: _____ Social Security #: _____

4. Category Applying For: Active Courtesy Consulting

5. TEXAS Medical License: _____ DEA: _____

6. Specialty: _____ Subspecialty: _____

7. Board Certification(s): _____

8. Describe the clinical functions you plan to request: _____

9. Practice Associates (if applicable): _____

10. List all hospitals in which you have held clinical privileges during the past 10 years. If needed, please attach a separate sheet of paper.

11. Professional / Sanction Information:

A. Have any of the following been or are any in the process of being denied, revoked, suspended, reduced, limited, restricted, placed on probation, not renewed, voluntarily or involuntarily relinquished, reduced, not renewed, withdrawn, lost or terminated or have you been subjected to disciplinary or corrective action or been the subject of any investigation which might lead to such action? **If yes, please attach details.**

Yes No

- | | | |
|---|--------------------------|--------------------------|
| 1) Medical licensure or registration in any state | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Drug Enforcement Administration Registration in any jurisdiction | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Membership, clinical privileges, functions, duties or prerogatives/rights on any medical or allied health staff at any hospital or other institution | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Professional liability insurance coverage | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Professional society membership | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Fellowship or specialty/subspecialty board certification status | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Academic appointment | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Professional office, to include private practice, employment, contractual agreement | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Any other professional registration/licensure, professional association or entity (local, county, state, or federal government) | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Have you been subject to a criminal conviction, or is any such action pending? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Do you have any past, current or pending sanctions affecting participation in any federal/state Health Care Program, or any actions which might cause you to become an Ineligible Person, or have you received a Professional Review Organization citation and/or a quality denial letter concerning alleged quality problems in patient care? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Have you had any citations by Medical Staff review committees, including quality care committees? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Have you had any malpractice claims, suits, judgments, settlements or arbitration proceedings pending, filed or settled? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Have you ever been rated in a higher than average liability insurance risk class for your professional specialty? | <input type="checkbox"/> | <input type="checkbox"/> |

I hereby extend immunity to and release from any and all liability, Valley Regional Medical Center and its authorized representatives, and any third parties for any acts, communications, reports, records, statements, documents, recommendations, or disclosures with respect to me, as performed, made, requested or received by Valley Regional Medical Center and its authorized representatives to, from, or by any third party, including otherwise privileged or confidential information. I understand that the foregoing shall be privileged to the fullest extent permitted by law. This release and immunity shall extend to the Valley Regional Medical Center and its authorized representatives, and to any third party, regardless of whether my request for an application is accepted; and whether or not an application is sent and subsequently processed. I hereby authorize Valley Regional Medical Center and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, any other matter that might directly or indirectly impact or reflect on my competence, on patient care, on the orderly operation of this or any other facility, or on my satisfaction of the requirements that Valley Regional Medical Center has determined appropriate to request an application to the Medical Staff or Allied Health Professional Staff, as well to inspect or obtain any and all communications, reports, records, statements, documents, recommendations and/or disclosures of said third parties relating to such questions. I also specifically authorize said third parties to release said information to Valley Regional Medical Center and its authorized representatives upon request.

 Signature of Requesting Practitioner

 Date