

- (3) Do you plan to establish or have you established an office near the hospital?
 Yes___ No___
- (4) Have any disciplinary actions or investigations been initiated or are pending against you by any State licensure board?
 Yes___ No___
- (5) Has your license to practice in any state ever been relinquished, denied, limited, suspended, revoked or voluntarily relinquished?
 Yes___ No___
- (6) Have you ever been asked to surrender your license?
 Yes___ No___
- (7) Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (for example, Medicare, Medicaid)?
 Yes___ No___
- (8) Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance programs?
 Yes___ No___
- (9) Has your narcotics registration certificate ever been relinquished, limited, suspended, revoked, or voluntarily relinquished?
 Yes___ No___
- (10) Have you ever been named as a defendant in any criminal proceedings?
 Yes___ No___
- (11) Have your employment, Medical Staff appointment, or clinical privileges ever been voluntarily or involuntarily suspended, diminished, revoked, refused, relinquished, or limited (except for failure to complete medical records) at any hospital or other health care facility?
 Yes___ No___
- (12) Are you planning to apply for appointment and clinical privileges at any other hospital?
 Yes_____ No___
- Hospital:_____ Address:_____
- Hospital:_____ Address:_____
- Hospital:_____ Address:_____
- (13) List three professional peer references who have had first-hand observation and otherwise, that you are highly qualified in regard to your:
- (a) background, experience, training, and demonstrated competence;
 - (b) adherence to the ethics of profession;
 - (c) reputation and character;
 - (d) ability to safely and competently exercise the requested clinical privileges;

(e) ability to work harmoniously with others sufficiently to convince the System that all patients treated at the System will receive quality care, and that the System and its medical staff will be able to operate in an orderly manner.

(1) _____
Name Title Phone Number

Street City State Zip Code

(2) _____
Name Title Phone Number

Street City State Zip Code

(3) _____
Name Title Phone Number

Street City State Zip Code

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

- (a) Current Georgia license to practice medicine;
- (b) DEA certificate;
- (c) Professional liability insurance policy certificate of coverage from insurance carrier;
- (d) ECFMG certificate (if foreign medical graduate);
- (e) A curriculum vitae, which will become part of your file;

(15) Have you actively practiced in your field of medicine full time at least 12 months within the past 24 months? _____ Yes _____ No

I request an application for appointment to the medical staff of Hutcheson Medical Center. I understand that completing this Pre-Application in no way obligates the hospital and/or medical staff to afford me medical staff membership or privileges.

As an applicant for staff appointment and privileges, I understand that it is my responsibility to produce adequate information so Hutcheson Medical Center can perform a proper evaluation of my application. I agree to provide Hutcheson Medical Center System with updated information regarding all questions on this pre-application form as new information becomes available. I also agree to provide Hutcheson Medical Center with additional information that one of its authorized representatives may request. Failure to produce any requested information will prevent my application from being processed.

As part of this request for application, I authorize Hutcheson Medical Center to obtain references on my qualifications and current clinical competence.

Signature

Date