Pre-Application Requirements

Thank you for your interest in medical staff membership and/or clinical privileges at Saint Agnes Hospital. In accordance with the medical staff bylaws, there are several requirements that must be met in order to be considered for a medical staff application form.

Requirements

You must:

➢ have a current, valid license to practice your respective profession in the State of Maryland;
➢ possess current federal Drug Enforcement Administration and Maryland Controlled Dangerous Substances registration numbers (this requirement is applicable for practitioners that prescribe narcotics or controlled dangerous substances);
➢ be Board Certified or Board Eligible;
➢ maintain professional liability insurance coverage meeting the minimum policy limits and other requirements established by St. Agnes Hospital;
➢ not be currently excluded or debarred from, or otherwise ineligible to participate in, any health care programs funded in whole or in part by the United States Government, including the Medicare and Medicaid programs.

If you meet the requirements listed above, you must complete a Pre-Application Form. The form bearing your handwritten signature can be submitted via email or fax to the Chairman of the clinical department you are interested in.

The email address or fax number can be obtained by contacting:

<table>
<thead>
<tr>
<th>Clinical Department</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>667-234-3045</td>
<td>(667) 234-4009</td>
</tr>
<tr>
<td>Diagnostic Imaging</td>
<td>667-234-3009</td>
<td>(667) 234-3429</td>
</tr>
<tr>
<td>Medicine</td>
<td>667-234-8723</td>
<td>(667) 234-3525</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>667-234-2626</td>
<td>(667) 234-2640</td>
</tr>
<tr>
<td>Pathology</td>
<td>667-234-3050</td>
<td>(667) 234-3572</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>667-234-2500</td>
<td>(667) 234-3549</td>
</tr>
<tr>
<td>Surgery</td>
<td>667-234-2748</td>
<td>(410) 951-4007</td>
</tr>
</tbody>
</table>
Medical Staff Pre-Application Form

This is not an application for medical staff membership or clinical privileges. The Pre-Application Form will be reviewed to determine eligibility to apply for medical staff membership and privileges with Saint Agnes Hospital. **Please type or legibly print the information requested.**

Name (last, first, middle):

Professional Degree:  □ MD  □ DO  □ Other: __________________________
(Please indicate degree type)

Clinical Specialty: ________________________________________________

Date of Birth: ___________________________ Social Security Number: ___________________________

Contact information below: Please check one  □ Office  □ Home

Address: ____________________________________________
Street                                      City                                    State,  Zip Code

Telephone: ___________________________

Email Address: ____________________________________________

I. EDUCATION AND TRAINING

Medical School: ___________________________ Date of Graduation: ___________________________

Internship: From: ___________ To: ___________

Residency: From: ___________ To: ___________

Residency Specialty: ____________________________

Fellowship: From: ___________ To: ___________

Fellowship Specialty: ____________________________

II. BOARD CERTIFICATION STATUS

□ Board Certified: ___________________________ □ Board Eligible

Specialty Board: ___________________________ Year Obtained: ___________________________
### III. HOSPITAL AFFILIATION
List the hospitals you are currently affiliated with (Primary on top).

<table>
<thead>
<tr>
<th>Hospital</th>
<th>City/State</th>
<th>Affiliation Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### IV. ST. AGNES HOSPITAL USAGE
Indicate the extent that you anticipate using the facilities at St. Agnes Hospital.

1. Number of Annual Admissions ________
2. Number of Annual Outpatient Procedures ________
3. Number of Annual Inpatient Procedures ________
4. Number of Annual Consultations ________
5. Percentage of your total practice ________%

### V. QUALIFICATIONS FOR MEMBERSHIP

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you currently hold an unrestricted license to practice in the State of Maryland?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you currently hold an unrestricted registration for controlled substances in the State of Maryland and Federal DEA Registration?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have any disciplinary actions or investigations ever been initiated, or are any disciplinary actions or investigations currently pending, against you by any hospital medical staff, hospital or medical staff committee, State licensure board, professional society, or other organization authorized to review your professional actions and take disciplinary action against you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your license to practice in any state ever been voluntarily or involuntarily relinquished, denied, limited, surrendered, suspended, revoked or relinquished?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (e.g., Medicare, Medicaid)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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 program?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your controlled substances certificate ever been voluntarily or involuntarily relinquished, limited, suspended, or revoked?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been named as a defendant in any criminal proceeding or in any civil proceeding related to your professional practice or actions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your medical staff appointment or clinical privileges ever been voluntarily or involuntarily suspended, limited, revoked, refused, denied, or relinquished at any hospital or other healthcare facility?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have professional liability insurance coverage with limits of liability at a minimum of $1,000,000/$3,000,000?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree to abide by the Ethical and Religious Directives for Catholic Health Care Services while practicing at St. Agnes Hospital?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
VI. REASON FOR JOINING SAINT AGNES MEDICAL STAFF: Please check one

☐ To be employed by Saint Agnes Hospital

☐ Joining group practice: __________________________________________

☐ Other: ________________________________________________________

I certify that all information provided in this Pre-Application Form is true and correct to the best of my knowledge, information, and belief.

I understand and acknowledge that this Pre-Application Form is not an offer to grant me Medical Staff membership or clinical privileges at St. Agnes Hospital. I also understand and acknowledge that neither St. Agnes Hospital’s provision of this Form to me, nor my completion and submission of this form to St. Agnes Hospital, obligates St. Agnes Hospital, its Medical Executive Committee, Medical Staff, or Board of Directors to provide me with an application of Medical Staff appointment or clinical privileges, or to offer or grant me such membership and privileges.

In consideration for Saint Agnes Hospital’s acceptance and review of my completed Pre-Application Form, I hereby release from all claims, damages and liability whatsoever: (1) Saint Agnes Hospital, its Medical Staff, and all Hospital and Medical Staff representatives for any action taken or statement or recommendation made by any such Hospital or Medical Staff representative within the scope of his or her duties as a Hospital or Medical Staff representative in compliance with the Medical Staff Bylaws and Procedures, including disclosures made to other health care entities pursuant to the Medical Staff Bylaws and Procedures; and (2) any third party for releasing or disclosing information, including otherwise privileged or confidential information, to any Saint Agnes Hospital or Medical Staff representative concerning me, unless such information is false and the third party providing it knew it was false. I also hereby consent to such disclosures and releases of information as are described in (1) and (2) above.

Applicants Signature: ___________________________ Date: ______________

Please send the completed Pre-Application Form to:
St. Agnes Hospital
Attention: Department Chairman
Department of <Name of Clinical Department>
900 Caton Avenue
Baltimore, MD 21229

FOR SAINT AGNES HOSPITAL USE ONLY

TO: Medical Staff Office
From: Department Chair

Send application for medical staff appointment to pre-applicant.

Will be: ☐ employed practitioner Anticipated start date: __________________________

☐ non-employed practitioner

Department Chairman Signature ___________________________ Date ______________