**St. John Health System**
**Medical Staff Pre Application**

**Check all applicable: SJMC ____ SJBA ____ SJO ____ SJS ____JPMC_____**

## I. IDENTIFICATION:

1. Name in full _____ MD DO DDS DMD DPM
   (Circle one)
2. Date of Birth _____ Social Security Number _____-_____-_____
3. E-mail address: _____ Phone: _____

## II. SPECIALTY/EDUCATION

1. Specialty in which clinical privileges will be requested: _____

   List any sub-specialty(ies) _____

2. Residency training:

   Facility _____

   Program _____ Dates (from/to) _____

   Facility _____

   Program _____ Dates (from/to) _____

   Facility _____

   Program _____ Dates (from/to) _____

3. Name of liability insurance company _____

   Amount of coverage _____/_____ Expiration Date _____
   per occurrence annual aggregate

4. Are you board certified in your specialty? □ Yes □ No*

   If "Yes", Name of Board _____

   *If "No", are you eligible for board certification? □ Yes o No

   If "Yes", date you are scheduled to sit for exam. _____

## III. EXPECTATIONS:

A "No" answer may disqualify you from receiving an application for appointment. Please completely explain any "No" answers on a separate sheet and reference by question number.

I expect to assist the system in fulfilling its mission in the following manner:

| | | |
|---|---|---|
| o Yes o No o N/A | 1. | Admit my patients in need of acute care services to the Hospital for required hospital care. |
| o Yes o No o N/A | 2. | Schedule and perform surgery at the Hospital, if applicable. |
| o Yes o No o N/A | 3. | Refer patients within the Hospital Medical Staff for definitive consultation, work-up, and on-site management. |
| o Yes o No o N/A | 4. | Refer patients within the Hospital Medical Staff for inpatient and outpatient surgical procedures or, if I am a surgeon, perform inpatient and outpatient surgical procedures on patients referred to me within the Hospital Medical Staff at the Hospital. |
| o Yes o No o N/A | 5. | Take ER call and assist the Hospital in providing emergency services to patients in need. |
| o Yes o No o N/A | 6. | I have arranged for continuing on-site coverage of my patients in the event I am unavailable or unobtainable. I will provide a letter signed by the individual or group that has agreed to provide coverage for me. |
| o Yes o No o N/A | 7. | Have a call-sharing arrangement with other Practitioners at the Hospital, if indicated. |
| o Yes o No o N/A | 8. | Participate in Medical Staff and hospital committees if requested. |
| o Yes o No o N/A | 9. | Comply with the Hospital CME requirements. |
| o Yes o No o N/A | 10. | Call Panel Expectations: |

a. As a member of the Hospital Medical Staff specializing in Family Practice, Pediatrics and Pediatric Non-surgical Subspecialties, Internal Medicine and Internal Medicine Subspecialties or Emergency Medicine, I will be automatically assigned to the appropriate call panel to provide emergency services to patients in need.

b. As a member of the Hospital Medical Staff specializing in Surgery and Surgical Subspecialties, Anesthesia or OB/GYN, I will be assigned to the appropriate specialty call panel to provide emergency consultations to patients in need.

c. As a member of the Hospital Medical Staff specializing in Radiology, Pathology or other sub-specialties, I will be called upon by other health care team members to consult regarding the work-up and management of patients at the Hospital.

## IV. AFFILIATION /PRACTICE INFORMATION

o Yes* o No 1. Check all that apply □ I am employed by

□ I am subsidized by

□ I am independently contracted

□ I am a shareholder, owner, or investor of

A hospital or healthcare facility other than the Hospital. This includes any health system or healthcare entity (profit or not-profit) in the healthcare business. *If "Yes", please indicate the name(s) of the facility(ies).

_____

_____

_____

_____

_____

o Yes* o No 2. I own an interest in or am a medical staff member of a surgicenter, diagnostic facility or other facility that competes directly for patients within the primary or secondary service areas of the Hospital. This includes any health system or healthcare entity (profit or not-profit) in the healthcare business. *If "Yes", please indicate the name(s) of the facility(ies).

_____

_____

_____

_____

_____

3. Please list the Hospital practice/Department you will be joining:

Practice Name _____

Practice Address _____

_____

Practice Phone _____Practice FAX _____

4. If your practice is new to the Hospital area, please list practice/group information:

   Practice Name _____

   Practice Address _____

   _____

   Practice Phone _____Practice FAX _____

   List all Practitioners in group/practice:

   _____

   _____

   _____

   _____

   I plan to have the following office hours:

   Specify hours: _____

   Circle days: Monday Tuesday Wednesday

   Thursday Friday Saturday

5. What will your scope of practice be at the facility(ies) at which you are applying? Please provide a brief narrative or summary.

   _____

   _____

   _____

   _____

   _____

   _____

## V. STAFF CATEGORY

- ☐ Active Staff – Using the Hospital as your primary hospital; attend meetings (with voting privileges) as required by the bylaws; admitting privileges

- ☐ Associate Staff – Using the Hospital as your non-primary hospital; no meeting attendance required; must be a member of Active Staff at another Oklahoma hospital; limited admitting privileges; utilization of outpatient services and facilities

I expressly agree that, in consideration for the Hospital's willingness to review this Intended Practice Plan and consider the information provided herein, I waive and release any claims, including but not limited to any claim of entitlement to a hearing or appellate review, against the Hospital, its Medical Staff and their officers, directors and agents, arising from a decision to not provide to me an application for membership on the Medical Staff. I expressly agree that such a decision is an administrative and business decision which may be made by the Hospital independent of any professional review and that such a decision will not result in any report to the National Practitioner Data Bank or any other agency. I also agree that if I am offered an application and granted Medical Staff privileges and fail to fulfill the conditions to which I have agreed in this Intended Practice Plan, my privileges may be administratively terminated without resort to the peer review processes and without giving rise to any claim of any nature against the Hospital, its Medical Staff and their officers, directors and agents. I hereby attest that the information provided above is true and correct. I fully understand that any significant misstatements in or omissions from this document constitute cause for denial of my request for an application, denial of appointment to the staff, denial of privileges, or termination from the staff. I will immediately notify the Hospital Medical Staff office if any information provided on this document changes or is no longer true and correct.

Signature:_____ Date: _____