Ascension St. John

**Medical Staff Pre Application**

## 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 subspecialty(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 ☐ 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:

| | |
|---|---|
| ☐ Yes ☐ No ☐ N/A | 1. Admit my patients in need of acute care services to the Hospital for required hospital care. |
| ☐ Yes ☐ No ☐ N/A | 2. Schedule and perform surgery at the Hospital, if applicable. |
| ☐ Yes ☐ No ☐ N/A | 3. Refer patients within the Hospital Medical Staff for definitive consultation, workup, and onsite management. |
| ☐ Yes ☐ No ☐ 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. |
| ☐ Yes ☐ No ☐ N/A | 5. Take ER call and assist the Hospital in providing emergency services to patients in need. |
| ☐ Yes ☐ No ☐ N/A | 6. I have arranged for continuing onsite 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. |
| ☐ Yes ☐ No ☐ N/A | 7. Have a callsharing arrangement with other Practitioners at the Hospital, if indicated. |
| ☐ Yes ☐ No ☐ N/A | 8. Participate in Medical Staff and hospital committees if requested. |
| ☐ Yes ☐ No ☐ N/A | 9. Comply with the Hospital CME requirements. |
| ☐ Yes ☐ No ☐ N/A | 10. Call Panel Expectations:<br>a. As a member of the Hospital Medical Staff specializing in Family Practice, Pediatrics and Pediatric Nonsurgical 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.<br>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.<br>c. As a member of the Hospital Medical Staff specializing in Radiology, Pathology or other subspecialties, I will be called upon by other health care team members to consult regarding the workup and management of patients at the Hospital. |

## IV. AFFILIATION /PRACTICE INFORMATION

☐ Yes* ☐ 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).

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☐ Yes* ☐ No

2. I own an interest in or am a medical staff member of a surgery center, 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).

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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

**Which will be your primary facility:**

- ❑ Ascension Jane Phillips Medical Center
- ❑ Ascension Jane Phillips Nowata Health Center
- ❑ Ascension St. John Broken Arrow
- ❑ Ascension St. John Medical Center
- ❑ Ascension St. John Owasso
- ❑ Ascension St. John Sapulpa

**Instructions:** Choose a category for each facility you wish to apply.

**Note:** All categories are initially considered provisional at St. John Medical Center & Jane Phillips Medical Center.

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### Ascension Jane Phillips Medical Center

- ❑ **Active:** For physicians who intend to participate in the medical, scientific, teaching, and charitable activities of the Hospital. It is expected that Active Staff members have a minimum of 12 patient encounters per year (24 per 2-year reappointment cycle).
- ❑ **Associate:** For those physicians who intend to treat patients infrequently (or not at all) at the hospital. Physicians on the Associate staff will be required to have a minimum of 6 patient encounters per year at the Hospital in order to retain clinical privileges. Those who do not meet the minimum requirement will not be granted clinical privileges at reappointment, but may maintain membership in the Associate category.
- ❑ **Consulting:** For Physicians who are not otherwise members of the Medical Staff and who meet the qualifications for membership, except that these requirements will not preclude an out-of-state practitioner from appointment as may be permitted by law if that practitioner is otherwise deemed qualified by the Medical Executive Committee.

### Ascension Jane Phillips Nowata Health Center

- ❑ **Active:** For physicians who intend to participate in the medical, scientific, teaching, and charitable activities of the Hospital. It is expected that Active Staff members have a minimum of 12 patient encounters per year (24 per 2-year reappointment cycle).
- ❑ **Associate:** For those physicians who intend to treat patients infrequently (or not at all) at the hospital.
- ❑ **Consulting:** For Physicians who are not otherwise members of the Medical Staff and who meet the qualifications for membership, except that these requirements will not preclude an out-of-state practitioner from appointment as may be permitted by law if that practitioner is otherwise deemed qualified by the Medical Executive Committee.

### Ascension St. John Broken Arrow

- ❑ **Active:** For physicians who intend to participate in the medical, scientific, teaching, and charitable activities of the hospital. It is expected that Active members be involved in the care of a significant number of patients at the hospital.
- ❑ **Associate:** For physicians who intend to admit patients infrequently to the hospital, and who wish to have access to the outpatient services offered by the hospital.

### Ascension St. John Medical Center

- ❑ **Active:** For physicians who have evidenced an interest in and concern for the Medical Center by participation in the medical, scientific, teaching, and charitable activities of the Medical Center. (It is expected that Attending Staff members be involved in the care of a significant number of patients at St. John Medical Center. The minimum number of admissions, consultations and/or procedures is determined under bylaws Article 6.3-3(D)
- ❑ **Consulting:** For physicians who are not otherwise members of the Medical Staff and who meet the qualifications for membership, except that these requirements will not preclude an out-of-state practitioner from appointment as may be permitted by law if that practitioner is otherwise deemed qualified by the Medical Executive Committee.
- ❑ **Courtesy:** Staff members of hospitals affiliated with other facilities accredited by the Joint Commission, DNV or any entity authorized by CMS to confer deemed status to the facility, who hold staff positions equivalent to our Attending Staff. A member is required to submit a letter attesting to his/her position on the active staff at another local hospital.

- ❑ **Affiliate:** For physicians who practice in the St. John Medical Center service area who would desire affiliation with the Medical Center for purposes of visiting their patients referred to or being cared for in St. John Medical Center, availing themselves of educational programs offered by or held within the Medical Center, or conducting teaching rounds for medical students and residents from medical schools affiliated with St. John Medical Center.

### Ascension St. John Owasso

- ❑ **Active:** For physicians who have evidenced an interest in and concern for the Hospital by participation in the medical, scientific, teaching, and charitable activities of the Hospital. It is expected that Active Staff members be involved in the care of a significant number of patients at Hospital.
- ❑ **Associate:** For physicians who intend to admit patients infrequently to the Hospital, and who wish to have access to the outpatient services offered by the Hospital.

### Ascension St. John Sapulpa

- ❑ **Active:** For physicians who regularly admit or otherwise be involved in patient care in the Hospital as determined by the CEO and the Hospital's Medical Staff such that quality review can be performed
- ❑ **Associate:** For physicians who infrequently admit and/or attend patients in the hospital.

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.

______________________________ ____________________

Applicant Signature Date