Fountain Valley Regional
HOSPITAL & MEDICAL CENTER
www.fountainvalleyhospital.com
17100 Euclid St., Fountain Valley, CA 92708

Medical Staff Services
Request for Application

PRACTITIONER INFORMATION			
Name:			
Date of Birth:	SSN:		NPI:
Current Office Address:			
City:		State:	ZIP:
Telephone:	Email:		Other Phone:
Primary Specialty:			
Sub Specialty:			
Name of Group:			

All questions must be completely and truthfully answered. If the answer is 'no' or if not applicable, please indicate.

Are you licensed in the state of California? ☐ Yes ☐ No
If no, please provide documentation that you have applied for licensure.
List other states in which you are currently or were previously licensed.

Are you certified by a Board which is a member of the American Board of Medical Specialties or the American Osteopathic Association; or by the American Dental Association, the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery? ☐ Yes ☐ No

If not currently Board Certified, have you completed training requirements which render you admissible for Board Certification by a Board recognized by the American Board of Medical Specialties or the American Osteopathic Association; or by the American Dental Association, the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery? ☐ Yes ☐ No

If "no", indicate when you will be considered admissible (month/year):_____

Do you have professional liability insurance coverage with limits of liability of a minimum of 1 million/occurrence, 3 million/aggregate from an insurance company licensed or approved to do business in California? ☐ Yes ☐ No

Have you ever been excluded, suspended, sanctioned or otherwise restricted from participating in any private, federal, state health insurance program (for example, Medicare, Medicaid), or is such action pending or in process?* ☐ Yes ☐ No

Do you plan to practice within the geographic service area of the hospital, i.e., close enough to fulfill your responsibilities and to provide timely and continuous care for your patients in the hospital? ☐ Yes ☐ No

Has your license to practice any profession in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, revoked, or is any such action pending or in process? * ☐ Yes ☐ No

Have you ever been investigated by any of the State Boards of Medicine?* ☐ Yes ☐ No

Are there currently any pending challenges to any licensure, registration or certification? *	☐ Yes	☐ No
Has your medical staff membership and/or clinical privileges ever been voluntarily or involuntarily denied, restricted, suspended, revoked, relinquished, terminated or is any such action pending or in process? *	☐ Yes	☐ No
Have you ever resigned from a professional position or appointment or allowed any professional license or certificate or appointment to lapse under threat of dismissal, discipline, non-renewal or other similar actions?*	☐ Yes	☐ No
Have you had any conviction of, withhold of adjudication for, or plea of guilty or no contest to, any felony, or any misdemeanor related to the crime against a person; practice of your profession; other health care related matters; third-party reimbursement; violence; or the use, prescription, distribution or furnishing of DEA scheduled drugs (Schedules I through V); or is any such action pending or in process?*	☐ Yes	☐ No
Do you have any pending or final felony or misdemeanor complaints, restraining orders or proceedings filed against you, or convictions of any felony or misdemeanors, in any jurisdiction?*	☐ Yes	☐ No

** If you respond "yes", please attach detailed explanation.*

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

- Current license (s) (all states)
- Narcotics registration certification (DEA) (Federal)
- Certificate of coverage from professional liability insurance carrier
- ECFMG certificate (if foreign medical graduate)
- List of current and previous hospital affiliations for the past ten years
- Evidence of successful completion of Medical or Dental School (or other professional school)
- Evidence of successful completion of an accredited postgraduate residency program in the specialty in which you will seek clinical privileges including copies of certificates
- Evidence of Board Certification or admissibility status, and
- Curriculum vitae which includes specific dates of your training and work history, as well as documentation of all time spans from completion of your Medical/Dental education through the present time.

I certify that I meet the criteria for membership as outlined in this REQUEST FOR APPLICATION. I understand that completing this questionnaire in no way obligates the hospital and/or medical staff to afford me Medical Staff membership or privileges.

I understand that I have the burden of producing adequate information for a proper evaluation of my current competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications. To accomplish this, I have provided the information requested within this document and agree to provide such other information as may be requested by Hospital or the Medical Staff at any time during the Request for Application process.

I understand that if I do not submit this completed Request for Application along with the required supporting documents within 30 days of my receipt of it, or if any information determined by Hospital as necessary to deem this Request for Application complete is not received within 30 days of a request for such additional information, this request for application shall be considered void, no further processing shall take place, and this Request for Application shall be deemed withdrawn.

I hereby release from liability any representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating my request for Medical Staff membership and privileges at Fountain Valley Regional Hospital , and I hereby release from liability any and all individuals and organizations who provide information to representatives of Fountain Valley Regional Hospital or its Medical Staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications, and I hereby consent to the release of such information.

I acknowledge that, if I am granted an application and ultimately Medical Staff membership and privileges at Fountain Valley Regional Hospital, all members are required, among other requirements, (i) to participate in the Emergency Department On-Call Roster as determined by the Member's Department(s) and the Medical Executive Committee; (ii) to treat the other physicians as well as employees, patients and visitors at Fountain Valley Regional Hospital in a professional and courteous manner and to refrain from disruptive conduct that adversely affects patient care and operations; (iii) to participate in relevant clinical practice guidelines or evidence-based order sets when such guidelines or order sets have been determined by the Member's Department(s) or the Medical Executive Committee to enhance patient outcomes and overall performance; and (iv) otherwise to abide by the Bylaws, rules and Regulations and policies of the Medical Staff and Bylaws of Fountain Valley Regional Hospital.

With my signature, I affirm that all information and documentation submitted in this Request for Application is truthful and accurate. I understand that providing any false or misleading information in this request for application shall be grounds for rejection of the request for application without any rights to further process.

Signature:	Date:
Print Name:	