



Medical Staff Pre-Application

Thank you for your interest in Davis Regional Medical Center.

We would like to take this opportunity to explain our application process, should you wish to apply for membership and clinical privileges at our facility.

Credentialing new applicants is a two-step process at Davis Regional Medical Center:

- ❖ The first step is to complete the pre-application form and return to the Medical Staff Office via. US Postal Service, Fax or Email. The pre-application is an assessment to determine eligibility to apply for Medical Staff Membership and/or Clinical Privileges.
- ❖ After review for eligibility, an application for Medical staff Membership and Clinical Privilege Request form will be sent. Attachments containing the Bylaws, Rules and Regulations and policy statements will be included with the application packet.

Completion of the pre-application does not guarantee privileges at Davis Regional Medical Center.

If you have any questions, please feel free to contact the Medical Staff Office at (704) 838-7567.

As stated in the first step, please return the application form to the Medical Staff Office

e-mail: cheryl.knight@hma.com

Fax: (704) 838-7557

US Postal Service: Davis Regional Medical Center

Attn: Cheryl E. Knight, CPCS

Medical Staff Office

218 Old Mocksville Road

Statesville, NC 28625



**DAVIS REGIONAL MEDICAL CENTER
PRE-APPLICATION QUESTIONNAIRE**

Last Name First Name Middle Name Social Security #

Other/Maiden Name Used Cell Phone # Email Address Pager Number

DOB (Month/Day/YR) Place of Birth Citizenship Sex (M/F)

Primary Office Address City State Zip Tax ID #

Telephone Number Fax Number "Back Line" Number NPI #

Home Address City State Zip Home Phone #

Marital Status Spouse Name

NOTE:

(1) If your specialty is a new service for this facility, there will be a delay while we develop delineation of privileges and criteria for those privileges.

(2) Davis Regional Medical Center has entered into exclusive contracts for physician services in the following area:

- Emergency Medicine - ApolloMD**
- Radiology – Charlotte Radiology**
- Pathology – Piedmont Pathology Associates**
- Anesthesiology – Unifour Anesthesia Group**

The Medical Staff office will not accept or process an application for Contracted Services, unless the physician is joining the group that has the contract with the hospital.

Please indicate the specialty in which you are requesting privileges: _____

Staff Appointment Status Desired

Active: **Courtesy:** **Consulting:** **Affiliate:**

To what extent do you anticipate using the facilities of Davis Regional Medical Center (Approximate number per year)

- (a) Admission** _____
- (b) Outpatient Procedures** _____
- (c) Inpatient Procedures** _____
- (d) Consultations** _____
- (e) Percentage of your total practice** _____ %

Part I. Pre-Application Questionnaire

Please read this section carefully.

This section is designed to help you determine if you meet the minimum requirements for membership on the Medical Staff of Davis Regional Medical Center. If you meet the qualifications outlined below in Part I, you may complete Part II of this form. If you do not meet these qualifications, you should not complete or return the pre-application form.

1. Are you licensed to practice in the state of North Carolina?
 - YES: Attach a copy of your current state license/registration certificate and proceed to question #2.
 - NO: You do not meet the minimum requirement for membership and clinical privileges.
2. Do you have professional liability insurance coverage with limits of liability at a minimum of \$1,000,000/\$3,000,000?
 - YES: Attach a copy of your Certificate of Insurance and proceed to question #3
 - NO: You do not meet the minimum requirement for membership and clinical privileges.
3. Have you successfully completed Medical School and Internship/Residency Program?
 - YES: Attach a copy of your Medical School Diploma and copies of your training certificates (Internship/Residency/Fellowship)
 - NO: You do not meet the minimum requirement for membership and clinical privileges unless: (1) you are in your last year of training program; and (2) you will complete the program within six months of the date you submit this application, and (3) you meet all other criteria listed above. If this is the case, you may proceed to question #4.
4. Are you Board Certified by an ABMS, AOA, ABPS, or American Dental board in the specialty in which you plan to practice or within five (6) years from completion of residency and board admissible in the specialty in which you plan to practice?
 - YES: Attach a copy of board certification or admission letter.
 - NO: You do not meet the minimum requirement for membership and clinical privileges.

PART II

Please circle yes or no for the following questions. Please attach an explanation for any questions to which you answer “yes.” If this Section does not have the provider’s signature, it cannot be accepted.

	YES	NO
1. Has your license to practice in any jurisdiction ever been limited, restricted, reduced, suspended, voluntarily surrendered, revoked, denied or not renewed; have you ever been reprimanded by a state licensing agency; or are any of these actions pending with respect to your license; are you under investigation by any licensing or regulatory agency? <i>(If yes, please complete Supplemental Question No. 1.)</i>	Y	N
2. Has your professional employment or membership in a professional organization ever been subject to disciplinary proceedings, denied, limited, restricted, reduced, suspended, revoked, not renewed, or voluntarily relinquished during or under threat of termination for any reason? <i>(If yes, please complete Supplemental Question No. 2.)</i>	Y	N
3. Has your Drug Enforcement Agency registration or other controlled substance authorization ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your registration during or under the threat of an investigation or are any such actions pending? <i>(If yes, please complete Supplemental Question No. 3.)</i>	Y	N
4. Have you ever been sanctioned or suspended by Medicare or Medicaid? <i>(If yes, please complete Supplemental Question No. 4.)</i>	Y	N
5. To your knowledge, have you ever been reported to the National Practitioner Data Bank or the North/South Carolina Board of Medical Examiners? <i>(If yes, please complete Supplemental Question No. 5.)</i>	Y	N
6. Have you ever been convicted of a felony or misdemeanor, or are you under investigation with respect to such conduct? <i>(If yes, please complete Supplemental Question No. 6.)</i>	Y	N
7. Has a professional liability claim been assessed against you in the past five years, or are there any professional liability cases pending against you? <i>(If yes, please complete Supplemental Question No. 7.)</i>	Y	N
8. Has any liability insurance carrier canceled, refused coverage, or rated up because of unusual risk or have any procedures been excluded from your coverage? <i>(If yes, please complete Supplemental Question No. 8.)</i>	Y	N
9. Have you ever practiced without liability coverage? <i>(If yes, please complete Supplemental Question No. 9.)</i>	Y	N
10. Do you currently have any medical, chemical dependency or psychiatric conditions that might adversely affect your ability to practice medicine or surgery or to perform the essential functions of your position? <i>(If yes, please complete Supplemental Question No. 10.)</i>	Y	N
11. Have your Hospital and/or Clinic privileges ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your privileges during or under the threat of an investigation or are any such actions pending? <i>(If yes, please complete Supplemental Question No. 11.)</i>	Y	N

Signature

Date

Note: The completion of this pre-application request form does NOT entitle one to the Fair Hearing Process.

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

- _____ Current license(s) to practice medicine
- _____ Narcotics registration certificate (DEA)
- _____ Proof of professional liability insurance policy and certificate of coverage which indicates the effective date, amount and classification of coverage.
- _____ Proof of your successful completion of post-graduate residency training program
- _____ Evidence of board certification or eligibility
- _____ ECFMG Certificate (if foreign medical student)
- _____ Copy of your CV
- _____ Copy of Driver's License and/or Passport

RELEASE AND IMMUNITY

I authorize the Hospital and its representative to consult with any third party who may have information bearing on my professional qualification, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter relative to my qualifications for privileges on the medical staff. This authorization includes the right to inspect or obtain any and all documents, recommendations, reports, statements, or disclosures relating to such questions. I also expressly authorize said third parties to release this information to the Hospital and its authorized representative upon request. I extend absolute immunity to, and release from any and all liability and agree not to sue the Hospital, its authorized representative and any third parties for any actions, recommendation, reports, statements, communications or disclosures involving me which are made, taken or received by the Hospital or its authorized representative.

I represent that information provided in or attached to this pre-application is accurate. I understand that a condition of this pre-application is that any misrepresentation, misstatement, or failure to meet the basic qualification outlined within the Medical Staff Bylaws will result in failure to process my application for medical staff privileges to Davis Regional Medical Center.

Signature

Date

