Request for Medical Staff Application (Pre-application)

PLEASE COMPLETE ONLINE, PRINT AND MAIL WITH COPIES OF REQURIED DOCUMENTS.

NOTE: The Pre-application must have no omitted responses and must include all required documents or processing will be delayed until received.

Mail with a $50.00 pre-application fee to:

Tampa General Hospital
Attn: Medical Staff Services
P.O. Box 1289
Tampa, FL 33601

Check made payable to:
TGH Medical Staff Activities Fund

Today's Date _____

Name in Full _____

(MD,DO,DPM,DDS, etc) _____

Social Security Number _____

Office Address _____ Suite # _____

Office City _____ State _____ Zip _____

Office Telephone _____ FAX _____

Email Address _____ @ _____

Residence Address _____

Residence City _____ State _____ Zip _____

Residence Telephone _____

Application to be mailed to: Office ____ Residence ____ (check one)

Name of Group _____

Year Accredited Residency/Fellowship Completed: _____

Board Certified in: _____

Year: _____

Board Status: Active Candidate – in application process

YES ____ NO ____ Year: _____

If not certified, is exam being taken?

YES ____ NO ____ When will exam be taken: _____

FL Medical License # _____

Has your Florida license always been in good standing? YES ___

If NO ____ Explain: _____

If no Florida Medical license #, has it been applied for?

YES ____ NO ____ When did you submit your completed application: _____

1. Please indicate your clinical specialty as well as any procedures or privileges outside of that specialty area that you are requesting.

   Specialty: _____

   Additional Clinical Privileges _____

2. To what extent do you anticipate using the facilities at Tampa General Hospital?

   _____

   A. Percentage of your total practice: _____

   B. Percentage of your total hospital practice: _____

3. Do you plan to establish, or have you established an office near the hospital?

   YES ____ NO ____

   Where? _____

4. Are you currently appointed to the Medical Staff of any other hospital?

   YES ____ NO ____

   If yes, please list below.

   Hospital _____

   Address _____

   Hospital City _____ State ____ Zip _____

   Hospital _____

   Address _____

   Hospital City _____ State ____ Zip _____

Hospital _____

Address _____

Hospital City _____ State ____ Zip _____

5. Have you actively practiced in your field in the previous 24 months (or have completed a 12-month residency/fellowship within the last 18 months)?

   YES ____NO ____

6. Do you participate in:

   A. Medicare? YES _____ NO _____ Medicare #_____

   B. Medicaid? YES _____ NO _____ Medicaid #_____

   C. UPIN #_____

   D. NPI # _____

7. Are you a sanctioned provider or have you ever been excluded, terminated, suspended or otherwise deemed ineligible for participation in government payment program?

   YES ____ NO ____

8. If appointed to the Medical Staff, will you agree to participate in emergency call rotation and to treat all patients referred to you, regardless of ability to pay?

   YES ____ NO ____

9. Are you employed by any other hospital or it's affiliate(s)?

   YES ____ NO ____

10. Do you have any business interests (including, but not limited to, ownership or investment in any freestanding health care facility) that would cause a conflict of interest with Tampa General Hospital's interests or mission?

    YES ____ NO ____

THIS FORM MUST BE RETURNED WITH COPIES OF THE FOLLOWING DOCUMENTS:

a. Current License(s) to practice medicine in Florida.
b. Current DEA registration.
c. Evidence of financial responsibility/professional liability coverage.
d. ECFMG certificate. (if foreign medical school graduate)
e. Evidence of successful completion of an approved postgraduate residency program.
f. Evidence of board certification or status.
g. Current curriculum vitae.
h. $50.00 pre-application fee

No application for appointment shall be provided to a practitioner, nor shall an application be accepted from a proposed applicant if the applicant does not meet the minimum requirements for Medical Staff membership. The minimum requirements for Medical Staff membership include but are not limited to: a current unrestricted license to practice medicine, podiatry, or dentistry in the state of Florida, unrestricted eligibility to participate in government payment programs, current DEA registration if applicable, evidence of financial responsibility/professional liability coverage, and board certification or board eligibility according to departmental requirements.

I request an application for appointment to the Medical Staff of Tampa General Hospital. I certify that I meet the prerequisites for receiving an application. I understand that the information requested on this pre-application questionnaire is sought to enable the hospital to make an administrative decision as to whether I am eligible to receive an application. I further understand that there may be additional departmental requirements that will be considered. The pre-application questionnaire does not constitute an application, and in no way obligates the hospital and/or Medical Staff to afford me Medical Staff membership or privileges.

I hereby release from any and all liability, and agree not to sue, the hospital and its representatives, for their actions in connection with evaluating the information provided on this questionnaire, and their determination as to whether or not I am eligible to receive an application. I understand that hearing rights under the Medical Staff Bylaws do not apply if I am determined to be ineligible to receive an application.

_____
Applicant Signature

_____
Date

_____
Printed Name

MEDICAL STAFF USE ONLY

COMMENTS:

_____

_____
Reviewer Name

_____

_____
Date

_____

_____
Reviewer Signature