



Mississippi Department of Mental Health

Mental Health Medical Staff Application

Program of Interest:

All information must be typed or legibly written. If more space is needed, attach additional sheets and make references to the question(s) being answered. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

Medical Specialty: _____

Position Applying For: _____

Medical Staff Category Applying For:

GENERAL INFORMATION

Name: _____
(First) (Middle) (Last) (Maiden) (Degree)

D.O.B.: _____ Birthplace: _____

Citizenship: USA Other: _____

Languages Spoken Other Than English: _____

*UPIN #: _____ *NPI #: _____ *Medicare #: _____ *Medicaid #: _____

**These numbers will be shared with authorized sources who request them.*

HOME ADDRESS

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone #: _____ Cell #: _____ Pager #: _____

Email Address: _____

Emergency Contact: _____ Phone #: _____

CURRENT PRACTICE (Please put N/A below if you are a recent graduate)

Practice Name: _____

Complete Address: _____

City: _____ State: _____ Zip: _____

Office Phone #: _____ Fax #: _____

SECONDARY PRACTICE

Practice Name: _____

Complete Address: _____

City: _____ State: _____ Zip: _____

Office Phone #: _____ Fax #: _____

EDUCATION AND TRAINING

MEDICAL EDUCATION

Name of School: _____

Complete Address: _____

City: _____ State: _____ Zip: _____

Dates Attended: _____ to _____

INTERNATIONAL MEDICAL GRADUATES

International medical school graduates, please indicate the following:

ECFMG Certificate Number: _____ Expiration Date: _____

Attach copies of: Copy of international medical school diploma translated in English
 If not a U.S. citizen, a copy of residency status

POST-GRADUATE TRAINING

You must complete the enclosed Education/Residency/Fellowship Verification Forms and mail them in order for your application to be processed.

Institution: _____ Type of Program: _____

Program Director: _____ Phone #: _____

Complete Address: _____

City: _____ State: _____ Zip: _____

Was Program Successfully Completed: _____ Dates Attended: _____ to _____

Institution: _____ Type of Program: _____

Program Director: _____ Phone #: _____

Complete Address: _____

City: _____ State: _____ Zip: _____

Was Program Successfully Completed: _____ Dates Attended: _____ to _____

Institution: _____ Type of Program: _____

Program Director: _____ Phone #: _____

Complete Address: _____

City: _____ State: _____ Zip: _____

Was Program Successfully Completed: _____ Dates Attended: _____ to _____

During your internship, residency, fellowship or teaching appointment, were you ever disciplined, suspended, placed on probation, reprimanded or asked to resign?

If you answered yes, please explain: _____

LICENSES AND CERTIFICATIONS

PROFESSIONAL LICENSE

Indicate all states in which you hold current or inactive license(s). Use a separate sheet of paper if necessary.

<u>State</u>	<u>License Number</u>	<u>Expiration</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

DEA

DEA Number: _____ Expiration: ____/____/____

I will not be NOT be prescribing Controlled Substances during my medical staff appointment.

BOARD CERTIFICATION/SPECIALTY

Name of specialty boards by which you are certified:

Name of Board: _____ Date Certified: _____ Expiration Date: _____

Name of Board: _____ Date Certified: _____ Expiration Date: _____

If not certified, when are you scheduled for certification examination? _____

Date(s) of next required recertification examination (if applicable): _____

PROFESSIONAL AFFILIATIONS

Since completion of training, list in chronological order all present and previous healthcare affiliations (include groups and hospitals), beginning with the most current (must include month and year). Please explain any gaps in time. This section must be completed. If more space is needed, please use another sheet of paper. You must complete the enclosed Hospital Affiliation Verification Forms and mail them in order for your application to be processed.

Facility Name: _____ Dates Affiliated: _____ to _____

Complete Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ Status: _____

Facility Name: _____ Dates Affiliated: _____ to _____

Complete Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ Status: _____

Facility Name: _____ Dates Affiliated: _____ to _____

Complete Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ Status: _____

Facility Name: _____ Dates Affiliated: _____ to _____

Complete Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ Status: _____

Facility Name: _____ Dates Affiliated: _____ to _____

Complete Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ Status: _____

PROFESSIONAL LIABILITY INFORMATION

Current Carrier: _____ Policy #: _____

Complete Address: _____

City: _____ State: _____ Zip: _____

Coverage Amounts: _____ Effective Date: _____ Expiration Date: _____

PROFESSIONAL REFERENCES

This section must be completed. "See Attached" will not be accepted.

Experienced Practitioners: Please provide the names of the Clinical Department Chairman or Chief of Staff of the facility where you have worked the most recently and two peer references who practice in the same specialty, have worked with or observed you in the past 3-5 years, and are knowledgeable about your professional experience and competence, your ability to work with others, and your ethical character.

New Graduates: If you completed your professional training within the last two years, please provide the names of the (1) Clinical Department Chairman, (2) Clinical Program Director in your specialty, and (3) a peer who practices in your specialty and who have worked with or observed you and are knowledgeable about your professional experience and competence, your ability to work with others, and your ethical character.

Name: _____ Phone #: _____ Fax #: _____
Clinical Department Chairman

Complete Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Name: _____ Phone #: _____ Fax #: _____
Peer Reference (Program Director if new graduate)

Complete Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Name: _____ Phone #: _____ Fax #: _____
Peer Reference

Complete Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

BACKGROUND INFORMATION

1. Are you currently having any medical, psychiatric, or other health problem(s) that would adversely affect your ability to carry out your duties? If Yes, please attach a report by selecting the paperclip on the left.

2. Have you been named as Defendant in a medical malpractice lawsuit?
If Yes, attach a detailed report including dates lawsuits commenced and concluded, the nature of the lawsuit(s), and the outcome of each.
3. Have your privileges at any hospital been voluntarily or involuntarily suspended, diminished, revoked, or not renewed or is any such action pending? If Yes, attach a detailed report.
4. Have you been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization or is any such action pending? If Yes, attach a detailed report.
5. Have you ever voluntarily or involuntarily relinquished privileges at any facility or in any jurisdiction?
If Yes, attach specific details, including dates and person(s) who may be contacted for verification.
6. Have you ever voluntarily or involuntarily relinquished any licenses, including professional licenses?
If Yes, attach specific details, including dates and person(s) who may be contacted for verification.
7. Have you ever voluntarily or involuntarily relinquished any registrations, including Drug Enforcement Administration registration? If Yes, attach specific details, including dates and person(s) who may be contacted for verification.
8. Do you have any health conditions which would impair your ability to attend patients regularly and provide safe, quality care to your patients? If Yes, attach detailed report of impairing conditions.

** If you answered "yes" above, please explain:

ACKNOWLEDGEMENT

I fully understand that any significant misstatement in, or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true to my best knowledge and belief.

In making this application for appointment to the medical staff of this hospital, I acknowledge that I have received and read the bylaws of the hospital as well as the bylaws and rules and regulations of the medical staff of this hospital, and that I am familiar with the principles and standards of the Joint Commission and the principle of ethics of the American Medical/Osteopathic Association, and I agree to be bound by the terms thereof if I am granted membership or clinical privileges. I further agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment to the medical staff, and I further agree to abide to such hospital and staff rules and regulations as may be from time to time enacted.

By applying for appointment to the medical staff, I hereby signify my willingness to appear for the interviews in regard to my application and authorize the hospital, its medical staff and their representatives to consult with administrators and members of medical staff of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the hospital, its medical staff and its representatives of all records and documents including medical records, at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release from liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the hospital, or its medical staff, in good faith without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by this hospital, or its medical staff to other hospitals and medical associations on request regarding any information the hospital and the medical staff may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability this hospital and its staff for doing so. All such correspondence shall be available to me.

I understand and agree that I, as an applicant for medical staff membership, have the burden of producing adequate information for proper evaluation of professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

I have not requested privileges for any procedures for which I am not qualified. I am familiar with the laws of this State governing the practice of medicine, dentistry, podiatry, advance practice nursing, and pledge to abide by these laws. I further certify that I have no health condition which would impair my ability to attend to my patients regularly and provide safe, quality care to my patients. I pledge continuous care to my patients.

Acknowledgement

Date

Applicant Signature

Appointment Recommended _____ Appointment Not Recommended _____ Appointment Deferred _____
to the Medical Staff of Mississippi State Hospital.

Requested Privileges Approved in (Specify): _____

Period of Initial Appointment: _____ to _____

Date

Clinical Director

Date

Hospital Director

Date

President, Board of Mental Health

* If you have additional certifications, please attach your certificates to the email before sending.