EL CENTRO REGIONAL MEDICAL CENTER

Medical Staff Credentialing

Pre-Application

A. POLICY: ESTABLISHING ELIGIBILITY.

1) Before receiving or submitting an initial application for appointment to the Medical or Allied Health Professional (AHP) Staff of El Centro Regional Medical Center (ECRMC), the prospective applicant must establish eligibility for consideration for membership and privileges. The prospective applicant must complete and submit this Pre-Application form. No application for Medical or Allied Health staff will be provided to a prospective applicant, nor will formal application be accepted, until the Pre-Application process confirms that the applicant is eligible to apply for membership and eligible to apply for their respective clinical privileges.

2) If it is determined that the prospective applicant meets eligibility criteria for membership and privileges, he/she will be provided an Application for Medical or Allied Health Professional staff membership and the appropriate clinical privilege delineation for ECRMC.

3) If a prospective applicant fails to establish eligibility, an Application for Medical or Allied Health Professional staff membership and privileges will not be provided. The prospective applicant will be sent written notice. The decision not to provide an Application is not considered a professional peer review action as it is not based on the professional competency or conduct of the prospective applicant, or medical disciplinary cause as defined in BP 805. It is not reportable to the National Practitioner Data Bank nor to the Medical Board of California. The prospective applicant who fails to establish eligibility shall not be entitled to hearing or appeal rights.

B. BASIC QUALIFICATIONS:

1) **Education and Training.** Able to document completion of medical education and training from approved accredited program

2) **Experience and Current Professional Competence.** Can demonstrate experience and current professional competency. Actively practicing clinical medicine within the past 24 months.

3) **Licensure.** Current, unrestricted Medical license issued by the State of California

4) **DEA.** Maintain current, unrestricted federal DEA registration

5) **Professional Liability Insurance**. Maintain current, valid professional liability insurance coverage in minimum amounts of: $1,000,000 per occurrence and $3,000,000 aggregate. The insurance will be with an insurance carrier admitted to market insurance in the State of California, or a Physician mutual cooperative trust, operated in compliance with California law. The insurance must apply to all patients the practitioner treats and to all procedures the practitioner has privileges to perform in the Hospital

6) **Alternate Coverage**. Each physician shall personally provide or otherwise arrange for continuous care and coverage for each of his or her patients who present to the Hospital for clinical care, emergency services, or who are currently Hospital inpatients. If a physician is unable to provide care for his or her patients, then the physician must provide coverage through another appropriately credentialed physician. The covering physician must be available and qualified to assume responsibility for the patients during the attending physician's absence and must be aware of the status and condition of any Hospital inpatient which he or she is to cover. Failure to arrange appropriate coverage shall be grounds for corrective action.

7) **Board Certification**. Established physicians: Must be board certified, and are expected to maintain their active certification status. New graduates: Are progressing towards certification by (1) boards which are duly organized and recognized by an American Board of Medical Specialties, or, (2) a board or association with equivalent requirements approved by the Medical Board of California, or, (3) a board or association with an Accreditation Council for Graduate Medical Education-approved postgraduate training program that provides complete training in that specialty or subspecialty. Applicants who are progressing toward board certification must become board certified within five years of the initial granting of medical staff membership.

C. THE PRACTITIONER DOES NOT MEET ESTABLISHED ELIGIBILITY CRITERIA IF, DURING THE PAST FIVE [5] YEARS:

1) Has been denied medical staff membership or reappointment, or under a peer review investigation which concluded with a reduction of clinical privileges or involuntary removal from the medical staff of any hospital;
2) Has revocation, termination, suspension, probation, restriction, or limitation of license by the Medical Board of California;
3) Has a record of restriction, limitation, denial, revocation, or termination of appointment or clinical privileges at any hospital or health plan for reasons related to professional competence or conduct;
4) Has resigned appointment or relinquishment of privileges during a medical staff investigation at any hospital;
5) Has a record of conviction of Medicare, Medicaid, or insurance fraud and abuse, payment of civil money penalties for same, or Exclusion form such programs.
6) DUI or other unacceptable information or conditions in their record.

- **Please send a copy of your current Medical Malpractice Insurance Certificate.**
- **Please include a copy of your Curriculum Vitae and a picture ID (Driver's License, Passport).**
- **A non-refundable, Pre-Application fee of $200.00 is due and payable upon submission of this application. Please make check payable to: ECRMC Medical Staff. Mail/deliver to: El Centro Regional Medical Center, Attn: Medical Staff Office, 1415 N. Ross Street, El Centro, CA 92243. (Note: Initial Application Fee is $400.00, however, if approved for an application, the remainder of your fee will be $200.00.)**
- **PLEASE BE AWARE THAT THE PRE-APPLICATION WILL NOT BE PROCESSED UNTIL RECEIPT OF PAYMENT.**

PLEASE RETURN THIS PRE-APPLICATION BY EMAIL TO medical-staff-support@ecrmc.org , via FAX at (760) 339-9904.

• **INSTRUCTIONS - This form should be typed or legibly printed in black or blue ink. All fields MUST be completed.** • **Please attach a copy of your CV and Malpractice Insurance Certificate.**

1. IDENTIFYING INFORMATION

Last Name:	First:	Middle:	Degree:
E Mail Address:		Cell Number:	
Residence Address, City, State, Zip:			
DOB:	Birth Place:	Social Security Number:	

2. PRACTICE INFORMATION

Specialty:	Subspecialty:
Office Address, City, State, Zip:	Name of Alternate Coverage:

Email:	Phone:	Fax:

3. EDUCATION AND TRAINING

Medical School:	Degree:	Date of Graduation: (mm/yy)
Internship:	Type:	Dates: From-To:
Residency:	Specialty:	Dates: From-To:
Fellowship:	Specialty:	Dates: From-To:

4. BOARD CERTIFICATION STATUS - NEW GRADUATE: ☐ Scheduled Date for Certification Exam:_____

BOARD CERTIFICATION STATUS - ESTABLISHED PHYSICIAN (*please complete below)

*Name of Issuing Board:	*Specialty:	*Date Certified:	*Expiration Date (if any):

5. MEDICAL LICENSURE/REGISTRATIONS

California State Medical License Number:	Issue Date:	Expiration Date:
Drug Enforcement Administration (DEA) Registration Number:	Expiration Date:	
Controlled Dangerous Substances Certificate (CDS) (if applicable):	Expiration Date:	
NPI Number:	ECFMG Number:	

6. CURRENT PROFESSIONAL LIABILITY

Insurance Carrier:	Policy No:	Effective date:	Expiration Date:

Have there been any closed, dismissed, or are there currently any pending malpractice claims, suits, settlements, or arbitration proceeding involving your professional practice within the **past 10-years?** (Separate sheet attached**)** ☐ NO ☐ YES. If yes, please indicate number of cases: _____ Please provide full details on separate sheet.

7. CURRENT HOSPITAL, (if none), PAST, OTHER INSTITUTIONAL AFFILIATIONS – List only two (2).

Hospital Name, City, State:	Department/Status:	Appointment Date:
Hospital Name, City, State:	Department/Status:	Appointment Date:

8. PROFESSIONAL PEER REFERENCES - List three (3) who are of your same specialty, include email contact information. At least one reference has to be someone that currently works with you in the same hospital. Include any practitioner(s) you know currently on staff at ECRMC.

Name:	Email:	Cell Phone:
Name:	Email:	Cell Phone:
Name:	Email:	Cell Phone:

9. ATTESTATION QUESTIONS- Please answer the following questions. If answer is **"YES",** please provide full details on separate sheet.

1) Have you ever been denied medical staff membership or reappointment, or under a peer review investigation which concluded with a reduction of clinical privileges or involuntary removal from the medical staff at any hospital?	**YES**	**NO**
2) Have you had a revocation, termination, suspension, probation, restriction, or limitation of license by the Medical Board of California, or any other State licensing board?	**YES**	**NO**
3) Have you had a restriction, limitation, denial, revocation, or termination of appointment or clinical privileges at any hospital or health plan for reasons related to professional competence or conduct?	**YES**	**NO**
4) Have you ever resigned or taken a leave of absence during, or, to avoid an investigation, or relinquished privileges during a medical staff investigation?	**YES**	**NO**
5) Do you have a record of conviction of Medicare, Medicaid, or insurance fraud and abuse, payment of civil money penalties for same, or Exclusion form such programs?	**YES**	**NO**

XII. PROFESSIONAL LIABILITY

Please explain any surcharges to your professional liability coverage on a Separate sheet.

CURRENT Insurance Carrier:	Policy No:	Effective date:	Expiration Date:
Mailing Address:	Per Claim Amount:	Aggregate Amount:	
City/State/Zip:	Carrier Phone:	Carrier Fax:	
Carrier Email:			

▪ **PAST -** Please list all of your professional liability carriers **within the past ten years**, other than the one listed above.

Past Insurance Carrier:	Policy No:	Effective date:	Expiration Date:
Mailing Address:	Per Claim Amount:	Aggregate Amount:	
City/State/Zip:	Carrier Phone:	Carrier Fax:	
Carrier Email:			
Past Insurance Carrier:	Policy No:	Effective date:	Expiration Date:
Mailing Address:	Per Claim Amount:	Aggregate Amount:	
City/State/Zip:	Carrier Phone:	Carrier Fax:	
Carrier Email:			
Past Insurance Carrier:	Policy No:	Effective date:	Expiration Date:
Mailing Address:	Per Claim Amount:	Aggregate Amount:	
City/State/Zip:	Carrier Phone:	Carrier Fax:	
Carrier Email:			
Past Insurance Carrier:	Policy No:	Effective date:	Expiration Date:
Mailing Address:	Per Claim Amount:	Aggregate Amount:	
City/State/Zip:	Carrier Phone:	Carrier Fax:	
Carrier Email:			
Past Insurance Carrier:	Policy No:	Effective date:	Expiration Date:
Mailing Address:	Per Claim Amount:	Aggregate Amount:	
City/State/Zip:	Carrier Phone:	Carrier Fax:	
Carrier Email:			

10. INFORMATION RELEASE/ACKNOWLEDGMENTS

• I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations, licensing authorities, background check company, and businesses and individuals acting as their agents, for the purpose of evaluating this pre-application regarding my professional training, experience, character, conduct and judgment ethics, and ability to work with others.

• During such time as this pre-application is being processed, I agree to update it should there be any change in the information provided, including, but not limited to:

1) The unstated suspension, revocation or nonrenewal of my license to practice medicine in California;
2) Any suspension, revocation or nonrenewal of my DEA or other controlled substances registration;
3) Any cancellation or nonrenewal of my professional liability insurance coverage.
4) Receipt of written notice of any adverse action against me by the Medical Board of California taken or pending, to: Any accusation filed, Temporary Restraining Order, Imposition of any Interim Suspension, Probation, Limitations affecting my license to practice medicine; Any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California or a report with the National Practitioner Data Bank; The denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges;
5) Any material reduction in my professional liability insurance coverage;
6) Receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action;
7) Conviction of any crime (excluding minor traffic violations); Receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I understand that this Pre-Application form is not an application for Medical Staff or Allied Health membership or clinical privileges. This Pre-Application is intended to determine if I, the prospective applicant, meets eligibility criteria for membership and privileges. If I, the prospective applicant, is determined to be eligible, I will be provided with an Application for Medical or Allied Health Professional staff membership, with the appropriate clinical privilege delineation for El Centro Regional Medical Center.

I acknowledge that receipt and completion of this Pre-Application form is not an offer to grant me Medical Staff Membership or Allied Health Professional membership or Clinical privileges at El Centro Regional Medical Center. I understand that submission of this Pre-Application form does not obligate ECRMC to provide me with an Application for Medical or Allied Health Professional staff membership and privileges.

I certify that all information provided on the Pre-Application form is true and correct to the best of my knowledge.

Print Name Here: _____ Practitioner Signature: _____

Date: _____

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