MOUNT ST JOHN'S MEDICAL CENTRE
INTERNSHIP PROGRAM

Clinical Privilege Application (complete name)

I. INSTRUCTIONS

This form must be typed or written clearly in black ink. If you need more pages when you answer the questions, enclose more pages and make reference to your question and go on with your answer. You should enclose copies of the following documents in this form: (These documents are requirements for the Practitioners

FILL OUT THIS FORM TOTALLY. If a section does not apply to you, mark only the box DOES NOT APPLY or write N/A in the chart.

You must attach copies of the following documents in this form: (These documents are requirements for the Practitioners)

- Professional License granted by the Country of _____
- Narcotic Certificate /License
- Validation of your Title
- Evidence of having satisfactorily completed the program of approved residence
- Curriculum Vitae (Chronological history beginning with your professional education)
- Validation by the Technical Council
- Registration in the Association or National-International School of your Specialty
- Professional Credits Sheet and Certificate of coverage granted by the bearer of Insurance

**** ALL SECTIONS MUST BE COMPLETED, A CURRICULUM VITAE IS NOT AN ACCEPTABLE APPLICATION**

II. PRACTITIONER'S INFORMATION

Surname (include suffix Mr. Jr. III.)	Name:	Middle Name:	Title/s:
If there is any other name with which you are known by reference, or in your licenses or academic institutions:			
Address: Country:		City: State:	Post Office Box:
Home Telephone Number: ( )	Mobile Phone: ( )	E-Mail Address:	
Date of Birth:	Place of Birth (State, City, Country)		Nationality:
Social Security Number:		Gender ☐ Male ☐ Female	
Specialty:	Sub-specialty (if applied):		
Other interests in the Professional Practice, investigations, etc.			

III. PROFESSIONAL DEGREE, REGISTERS AND CERTIFICATIONS (Use an additional page if necessary)		
Number of License /Register:	Given on (date):	Date of Expiration:
Registration for the Handling of Narcotics:		Date of Expiration:

IV. OTHER LICENSES, REGISTERS AND PROFESSIONAL CERTIFICATIONS					
United States:	Number of License:	Obtained: (year):	Expires:	Resignation (year)	Reason:
Other country:	Number of License:	Obtained: (year)	Expires	Resignation (year)	Reason:
Other country:	Number of License:	Obtained: (year)	Expires	Resignation (year)	Reason:

V. CURRENT PRACTITIONER'S INFORMATION

☐ Practice Established ☐ Practice beginning date_____

Please respond the following questions totally. If the any of the answers is affirmative, please provide detailed information in a separate sheet.

1. Have you ever worked with Prepaid Health Plans? ☐ Yes ☐ No

2. Are you familiarized with the use of the CPT-4 and ICD-10 Codes? ☐ Yes ☐ No

3. Have you been exposed to any disciplinary action or do they have any action against you in any Medical Board or Association? ☐ Yes ☐ No

4. Have any of your licenses been denied, suspended, limited or revoked? ☐ Yes ☐ No

5 Have you ever been suspended, sanctioned or restricted from participating in any health insurance program, public or private? ☐ Yes ☐ No

6. Have you ever been subject of investigation on the part of any Health insurance program, private or public? ☐ Yes ☐ No

7. Has your license to handle narcotics ever been limited, suspended or revoked? ☐ Yes ☐ No

8. Have you ever been accused in any criminal procedure? ☐ Yes ☐ No

9. Have you been sued for malpractice? Do you have any open lawsuits or judgments against you ☐ Yes ☐ No		
Name of the Clinic or place where you practice:	If a Hospital, name of the department:	
Address of the main office:	City:	
	State/Province:	Post Office Box:
Telephone Number for patients' appointments: ( )	Fax Number: ( )	
Post Office Box (if different from the previous one):		
Billing Address (if different from the previous one):		
Office Administration:	Administration Telephone number ( )	
	Fax Number: ( )	
Name affiliated for the payment of taxes:	Number of Fiscal Taxpayer:	

VI. OTHER AFFILIATIONS IN HOSPITALS AND OTHER INSTITUTIONS

Please list, in inverse chronological order (finishing with current affiliation) all the institutions where you are and have been affiliated (Include hospitals, surgery centers, institutions, corporations, military assignments or government agencies. If you need more space, add additional sheets.

1. Has your employment or medical privileges ever been limited, reduced or terminated in any hospital or other health institution? ☐ Yes ☐ No
2. Have you voluntarily declined your membership to appoint, give appointments and clinical privileges or voluntarily resigned from the medical staff before the hospital or health care installation board would issue a decision? ☐ Yes ☐ No
3. Have you ever been object of disciplinary measures in any hospital or health institution? ☐ Yes ☐ No

If any of your answers was "Yes", please provide a wide explanation of the same in a separate sheet.

A. AFFILIATIONS IN PROGRESS

Name and Post Office Box of the main Hospital:	Department:
Status (Active, provisional, courtesy, temporal, etc)	Date of Appointment:

Name and Post Office Box of the Secondary Hospital:	Department:
Status:	Date of Appointment:
Name and Post Office Box of another institution:	Department:
Status:	Date of Appointment:
If you do not have hospital privileges, please explain in a separate sheet (the doctors without privileges should provide a plan of medical continuity)	

B. APPLICATIONS IN PROGRESS	
Name and address of the Hospital / Institution:	Date of Admission:
Name and address of the Hospital / Institution:	Date of Admission:

C. PREVIOUS AFFILIATIONS			
Name and Address of the Affiliation:			Department:
From (month/year)	Until (month/year)	Reason for suspension of the affiliation:	
Name and Address of the affiliation:			Department:
From (month/year)	Until (month/year)	Reason for suspension of the affiliation:	
Name and Address of the Affiliation:			Department:
From (month/year)	Until (month/year)	Reason for suspension of the affiliation:	
Name and Address of the Affiliation:			Department:
From (month/year)	Until (month/year)	Reason for suspension of the affiliation:	

VII. PRE-DOCTORAL (BACHELOR'S DEGREE)		
College or University:	Title Received	Date of Graduation:
Address:	City:	State and Postal Code:

VIII. MEDICAL EDUCATION			
School of Medicine:		Title Obtained:	Date of Graduation:
Address:	City:	State:	Postal Code:
School of Medicine:		Title Obtained:	Date of Graduation:
Address:	City:	State:	Postal Code:

IX. MORE INFORMATION IN MEDICAL EDUCATION (Add page if necessary))				**Not Applicable** ☐
INSTITUTION:	Address:	City:	State:	Postal Code:
Attended in (month/year - month/year): (/) - (/)	Program or Study Taken:	Director of the Faculty:		

X. INTERNSHIPS (Attach sheet if necessary)			**Not Applicable** ☐
Institution:	Telephone Number:	Program Director:	
Address:	City:	State:	Postal Code:
Type of Internship:	Specialty:	From (month/year):	To (month/year):

XI. RESIDENCE (Attach sheet if necessary)			**Not Applicable** ☐
Institution:	Telephone Number:	Program Director:	
Address:	City:	State:	Postal Code:
Type of Residence:	Specialty:	From (month/year):	To (month/year):
Did you successfully complete the program? ☐ Yes ☐ No (If the answer is "No", please explain the reasons in a separate sheet)			

Institution:	Telephone Number:	Program Director:	
Address:	City:	State:	Postal Code:
Type of Residence:	Specialty:	From (month/year):	To (month/year):
Did you successfully complete the program? ☐ Yes ☐ No (If the answer is "No", please explain the reasons in a separate sheet)			

XII. SUB SPECIALTY (Attach sheet if necessary)			**Not Applicable** ☐	
Institution:	Address:	City:	State	Postal Code:
Attended (month/year - month/year): (/) - (/)	Course:	Program Director:		
Did you successfully complete the program? ☐ Yes ☐ No (If the answer is "No", please explain the reasons in a separate sheet)				
Institution:	Address:	City:	State:	Postal Code:
Attended (month/year - month/year): (/) - (/)	Course:	Program Director:		
Did you successfully complete the program? ☐ Yes ☐ No (If the answer is "No", please explain the reasons in a separate sheet)				

XIII. PRECEPTORSHIP (Attach sheet if necessary)			**Not Applicable** ☐	
Institution:	Address:	City:	State:	Postal Code:
Attended (month/year - month/year): (/) - (/)	Course:	Program Director:		
XIV. TEACHING FACULTY/ CLASSES (Attach sheet if necessary)			**Not Applicable** ☐	
Institution:	Address:	City:	State:	Postal Code:
Attended (month/year - month/year): (/) - (/)	Position:	Faculty Director:		

XV. CERTIFICATION BY THE BOARD OF DIRECTORS	**Not Applicable** ☐
1. Have you ever been examined by a Special Board and the results have failed? ☐ Yes ☐ No If the answer is Yes, please give us details.	
2. Have you been certified, have you applied for any certification exam? ☐ Yes ☐ No If the answer is No, do you have any intention to apply for one? ☐ Yes ☐ No	
3. Have you been accepted to take the certification exam? ☐ Yes ☐ No If the answer is Yes, what are the dates of the exam?	

XVI. OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS (i.e., Fluoroscopy, X-Ray, etc.) (Attach copy of the Certificates if they apply)		
Basic Life Support Date….. Expiration **BLS**	**Advanced** Date Expiration **ACLS**	
Date - Expiration **PALS**	**Advanced** Date - Expiration **ATLS**	**Other** Date - Expiration

XVII. LABOR HISTORY					
Please list the work places or periods of time between Education and Affiliations to Institutions that have not been annotated in others parts of this application.					
Institution/Contracting Company:	Contact:			Telephone Number: ( )	
				Fax Number: ( )	
Address:	City:	State:	Postal Code:	From (month/year):	To (month/year):
Institution/Contracting Company:	Contact:			Telephone Number: ( )	
				Fax Number: ( )	
Address:	City:	State:	Postal Code:	From (month/year):	To (month/year):
Institution/Contracting Company:	Contact:			Telephone Number: ( )	
				Fax Number: ( )	
Address:	City:	State:	Postal Code:	From (month/year):	To (month/year):

XVIII. REFERENCES

Enumerate three personal references, preferably of your specialty, without including parents, current or future partners or persons associated to you. If possible, include at least a member of the Medical Team of each institution in which you have had privileges.

NOTE: The References must be from individuals who recently have observed and are acquainted with your work.

Name:	Title:	Telephone Number: ( )	
Address:	City:	State:	Postal Code:
Name:	Title:	Telephone Number: ( )	
Address:	City:	State:	Address:
Name:	Title:	Telephone Number: ( )	
Address:	City:	State:	Address:

XIX. PROFESSIONAL AFFILIATIONS

Please list the names of the Professional Corporations in which you have Membership - Complete name of the corporation:	Admission Date	Is currently a member
	/ / .	☐ YES ☐ NO
	/ / .	☐ YES ☐ NO

XX. HEALTH CONDITION

If any of the answers is affirmative, please provide us with detailed information in a separate sheet, including a description of any adaptation that could reasonably be made to facilitate your performance in such duties without risk.

1. At present, do you suffer from a physical or mental condition, including dependence on alcohol or drug that affects or that it is expected to make progress in the next 2 years to the point of affecting your ability to perform the expected clinical privileges or other medical tasks? ☐ Yes ☐ No
2. At present, are you taking medicines, under treatment for a condition that can affect your ability, medical performance or medical obligations once the treatment / medicine is discontinued? ☐ Yes ☐ No
3. Have you been hospitalized in the last 5 years or received institutional care for any condition / problem as the one described in the previous questions? ☐ Yes ☐ No

*Recent date of the physical exam_____ Made by _____

_____

_____

XXI. CERTIFICATION

I certify that all the information contained in this application is complete, correct and updated. I acknowledge that any lack or omission of information to this application constitutes a cause for denial. A copy of this application has the same value and effect of the original. I have reviewed this information up to the date recently obtained.

Name (Print): _____

Signature: _____
(Rubber stamp is not applicable)

Date: _____