

REQUEST FOR MEDICAL STAFF APPLICATION

ALLIED HEALTH PRACTITIONER: The applicant's Curriculum Vitae must accompany this form

Practitioner Name: _____ Degree: _____

Office Name: _____

Practitioner Address: _____

Telephone: _____ Fax: _____ Specialty: _____

Does the applicant hold any certifications? Y _____ N _____

NCCPA _____ ANCC _____ AANA _____ Other _____

Sponsoring Physician Name: _____
If non-Botsford Hospital Employee

Who is providing Professional Liability Insurance? Hospital: _____ Physician: _____

Does the applicant hold a current State of Michigan License/Registration? Y _____ N _____

Does the applicant hold a current Specialty License? Y _____ N _____

Does the applicant hold a current DEA certificate? Y _____ N _____

Are you currently/or were ever under investigation with any licensing board?

YES* NO *If Yes, please explain below:

Have you been or are you now suspended, excluded, barred, sanctioned or ineligible under the Medicare program, any Medicaid program, or any other private or federal program or agency for the payment or provision of medical services?

YES* NO *If Yes, please explain below:

By making a request for a Medical Staff Application, I accept the following conditions regardless of whether or not I am provided a Medical Staff Application and intend to be legally bound thereby. These conditions are in addition to any other exculpatory clauses, releases or waivers contained in the Medical Staff Bylaws: To the fullest extent permitted by law, I extend absolute immunity to, and release from any and all liability, and agree not to sue Botsford Hospital and/or its authorized representatives, for any action, recommendation, reports, statement, communications, or disclosures, performed without malice and/or in the absence of gross negligence, involving me, which are made, taken, or received by Botsford Hospital/and or its authorized representatives relating to or in connection with evaluation of my Request for Medical Staff Application.

I request an application for appointment to the Medical Staff of Botsford Hospital. I understand that the information requested on this pre-application questionnaire is sought to enable the hospital to make an administrative determination as to whether I am eligible to receive an application.

Signature

Date

Return Request Form and CV by Email or fax (248) 471-8837
 Tamara Musch, Credentials Coordinator • Medical Administration • 28050 Grand River Ave • Farmington Hills, 48336 • (248) 471-8820