



PRE-APPLICATION QUESTIONNAIRE & INTENDED PRACTICE PLAN

DEMOGRAPHICS

Name _____ Degree _____ DOB _____ Gender _____

Office Address _____ Phone _____ Fax _____

(Street, Suite #, City, Zip)

Residence Address _____ Home Phone _____

(Street, City, Zip)

SSN _____ Cell Phone/Pager _____ E-mail address _____

PRACTICE INFORMATION

Please check whether you will apply at CRMC, MGMC, or both:

Chandler Regional Medical Center Mercy Gilbert Medical Center Both Hospitals

Clinical Specialty _____

(PRACTITIONERS WHOSE AFFILIATION AND PRIVILEGES WILL BE LIMITED TO URGENT CARE MAY PROCEED TO THE "MINIMUM QUALIFICATIONS" SECTION.)

I intend to establish/join a practice (or already have an established practice) in the Chandler/Gilbert Community Yes No

If joining/practicing with a group, please list name of group and physicians within the group. _____

Please list the name(s) of your covering physicians (must be a physician on staff in same specialty, not a hospitalist)

Will you be admitting your patients in need of hospitalization to CRMC and/or MGMC? Yes No

If no, will you be referring your patients in need of hospitalization to CRMC and/or MGMC? Yes No

Name of physician/hospitalist group who will admit your patients: _____

MINIMUM QUALIFICATIONS

The following questions address the minimum criteria that must be met in order to receive an application for staff membership and privileges at Chandler Regional Medical Center and Mercy Gilbert Medical Center.

Do you hold a current and valid **unrestricted** license to practice in the State of Arizona? (attach copy) Yes No

Do you hold a current and valid **unrestricted** Drug Enforcement Administration (DEA) certificate? (attach copy) Yes No

Are you Board Certified in your declared specialty? Yes No

If no, are you Board Admissible or in the exam process? Yes No

Name of Certifying Board _____

Year of residency/fellowship completion _____

(Attach copy of Board Certificate or other evidence of certification/admissibility) Bylaws Requirement: "Be "board certified" or be an "active board candidate" for less than seven (7) years after completion of residency/fellowship training in a board approved by the American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Podiatric Surgery" or, "Completion of at least one year of a hospital based residency approved by the American Dental Association for dentists".

Have you been actively engaged in a clinical practice at least six of the last 12 months?
(residency/fellowship or private practice) Yes No

Have you actively practiced in a hospital for a least two of the past five years?
(12 months in a full-time clinical residency/fellowship will be considered equivalent)
Yes No

Do you maintain professional liability insurance in the amounts of at least \$1 million/\$3 million? (attach copy) Yes
No

If your answer to any of the above questions is "No", please provide explanation: _____

The following documents must be returned with this completed Pre-Application Questionnaire/Intended Practice Plan:

- Copy of current unrestricted AZ license
- Copy of current unrestricted DEA certificate
- Proof of professional liability insurance coverage that includes the dates of coverage and amounts of coverage
- Evidence of Board Certification OR Board Admissibility Status from the applicable specialty board in which you will be seeking privileges
- Copy of current CV

I request an application for appointment to the Medical Staff of Chandler Regional Medical Center and/or Mercy Gilbert Medical Center. I certify that I meet the pre-requisites for receiving an application. I understand that the information requested on this Pre-Application Questionnaire & Intended Practice Plan will be used to make a determination as to whether I am eligible to receive an application. This Pre-Application Questionnaire & Intended Practice Plan does not constitute an application.

I hereby release from any and all liability, and agree not to sue, Catholic Healthcare West, its affiliates and their representatives for their actions in connection with evaluating the information provided on this form and determining whether or not I am eligible to receive an application. I understand that a determination that I am not eligible to receive an application does not entitle me to any hearing rights under the Medical Staff Bylaws and Fair Hearing Plan.

Signature _____ Date _____

RETURN COMPLETED FORM, ALONG WITH SUPPLEMENTAL ITEMS, TO:

**MERCY GILBERT MEDICAL CENTER
MEDICAL STAFF SERVICES / CREDENTIALS VERIFICATION OFFICE
3555 S VAL VISTA DRIVE
GILBERT, AZ 85297**