

ST. MARY'S HOSPITAL  
WATERBURY, CONNECTICUT 06706

INSTRUCTIONS FOR APPLICATION REQUEST FORM

Thank you for your interest in St. Mary's Hospital. Pursuant to Board policy all individuals seeking appointment to the Medical and Dental Staff of St. Mary's Hospital are asked to complete the Application Request Form. Applications may be mailed to applicants after consideration of criteria, which include but are not, limited to the following:

- 1) Are licensed to practice in the State of Connecticut, or licensure has been applied for and is pending.
- 2) Have actively practiced their relevant clinical specialty or been in training for at least 18 months of the past 24 months.
- 3) Have established or plan to establish an office and residence in the commuting area of the hospital or can document coverage with practitioners who do.
- 4) Presently have privileges in an accredited hospital so that current references regarding your performance as a staff member can be evaluated.
- 5) Have a current DEA (Drug Enforcement Administration) number or is pending.
- 6) Maintain professional liability insurance with a minimum amount to be determined by each clinical department.
- 7) Are Board certified or eligible (i.e. have completed an approved training program) in your specialty.
- 8) Agree to participate in Medical Staff activities such as attending meetings or committees as defined by the Bylaws and Medical Staff rules and procedures.

I agree with the above and would like to submit a request for an application. Upon receipt of the Application Request Form, the information will be reviewed and you may be sent an application.

Completed applications will be reviewed by the Credentials and Executive Committees of the Medical Staff. If all required information is received promptly, you can expect the processing to take approximately three months. Following these steps, the final decision is made by the Board of Directors.

Revised 06/16/99

PLEASE RETURN TO:  
Medical Staff Office  
St. Mary's Hospital  
56 Franklin Street  
Waterbury, CT 06706  
Fax: (203) 709-8741

**APPLICATION REQUEST FORM**

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**PHONE #:** \_\_\_\_\_

**E-MAIL:** \_\_\_\_\_

Please provide the following information:

**A)** Have you ever practiced under another name? Yes  No

If yes, please provide name: \_\_\_\_\_

**B)** Are you licensed to practice medicine in Connecticut? Yes  No

If yes, please attach copy. If no, has application for license been made? Yes  No

**C)** My area of clinical interest or specialty is: \_\_\_\_\_

Are you Board Certified Board Eligible In Training

If in training, number of months to graduation: \_\_\_\_\_

**D)** Are you presently practicing your chosen specialty? Yes  No

**E)** Do you  intend to establish an office  have established an office?

Date: \_\_\_\_\_ Address: \_\_\_\_\_

Or are you seeking privileges for a temporary, part time position? Yes  No

If yes, in what Department? \_\_\_\_\_

**F)** Do you plan to establish a residence within commuting distance of St. Mary's Hospital? Yes  No

**G)** List in chronological order all hospitals in which you have had clinical privileges or been in training in the past five years. Use additional sheet if needed.

<b>Hospital</b>	<b>Address</b>	<b>Dates</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**H)** DEA # \_\_\_\_\_

My DEA number is applied for and is pending: Yes  No

**I) Professional liability insurance coverage:**

Company: \_\_\_\_\_ Amounts: \_\_\_\_\_

My professional liability coverage is applied for and is pending: Yes  No

Have you ever been refused coverage by any company or refused renewal of coverage by any company?

Yes  No

If yes, please provide details below or forward information separately.

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Have you been named as a defendant in a malpractice action within the past five years or received any letter with intent to sue? Yes  No

If yes, please provide details below or forward information separately.

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**J) To the best of your knowledge are you suffering from any disorder or illness (mental or physical) that limits or interferes with your ability to perform professional and staff duties fully? Yes  No**

If yes, please provide details below or forward information separately.

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**K) What is your Medicare Provider Number? \_\_\_\_\_**

**L) Are you under review by Medicare/Medicaid/Champus? Yes  No**

If yes, please provide details below or forward information separately.

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**M) Have you ever been excluded from participation in Medicare, Medicaid or from any other Federal or State assistance program? Yes  No**

If yes, please provide details below or forward information separately.

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**N) What is your Unique Provider Identification Number (UPIN)? \_\_\_\_\_**

**O) Do you have applications pending at other hospitals? Yes  No**

If yes, please provide details below or forward information separately.

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**P) I will accept the responsibilities of Medical Staff membership as outlined in the Bylaws, and Rules and Procedures of the Medical Staff. Yes  No**

I attest to the veracity of the above, and request an application form for the Medical Staff of St. Mary's Hospital.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date