Medical-Dental Staff Services
100 Hygeia Drive, Suite 2100
Newark, DE 19713
MDSS@ChristianaCare.org
(302) 623-2593 Fax
(303) 623-2597 Phone

REQUEST FOR APPLICATION

Name:______________________________ **Date of Birth:** ____________
Last First Middle

Provider E-mail address: ______________________ **Estimated Start Date:** ____________

☐ **MD** ☐ **DO** ☐ **DPM** ☐ **Other**: ______________ **Gender:** ☐ **Male** ☐ **Female**

NPI: ____________ **SSN:** ____________ **Specialty**: ______________________

Home Address:

Home Phone: ____________

Street Address City, State ZIP

Current Office Address:

Current Office Phone: ____________

Fax: ____________

Street Address City, State ZIP

Are you joining a practice? **Yes** ☐ **No** ☐ **If yes, provide the following information:**

New Practice Address:

New Office Phone: ____________

Practice Name

Fax: ____________

Street Address City, State ZIP

Best way of contacting you: ☐ **Home** ☐ **Current Office Address** ☐ **E-mail** ☐ **Phone**

Are you licensed in the state of Delaware? **Yes** ☐ **No** ☐ **If not, when did you apply?** ____________

Do you have a Federal DEA with a Delaware practice address? **Yes** **No**

Do you have a Delaware controlled substance registration? **Yes** **No**

Medical/Other School:______________________ **Degree:**________ **Dates:** ____________
From To

Postgraduate:

Type Program Institution/State From: To:

Type Program Institution/State From: To:

Type Program Institution/State From: To:

Board/Other Certification:

Are you board certified or board eligible? ☐ Yes ☐ No **(If no, you will need to apply for a waiver)** ☐ **N/A**

If not board certified, provide board eligibility date: ______________________

Specialty:____________________ Date of Certification:__________ Board: ____________________

Subspecialty:________________ Date of Certification:__________ Board: ____________________

Are the above-board certification(s) conferred by an affiliated Board of the American Board of Medical Specialties ("ABMS"), the American Osteopathic Association ("AOA"), the American Board of Oral and Maxillofacial Surgery, the American Board of Podiatric Surgery, or the American Board of Psychology? ☐ **Yes** ☐ **No** ***(If no, you may need to apply for a waiver)***

Have you been clinically active for at least two (2) of the last four (4) years? ☐ **Yes** ☐ **No**

	Please answer the following questions	**Yes**	**No**
1.	Have you ever had your professional license revoked, restricted, or suspended by a licensing agency?	☐	☐
2.	Have you ever been convicted of Medicare, Medicaid or any other federal or state governmental or private third-party payor fraud or program abuse or been required to pay civil penalties for the same?	☐	☐
3.	Have you ever been, excluded or precluded from participation in Medicare, Medicaid, or any other federal of state governmental health care program?	☐	☐
4.	Have you ever had your Medical Staff appointment, clinical privileges revoked, suspended, restricted, or terminated by any health care facility for reasons related to clinical competence or professional conduct?	☐	☐
5	Have you ever resigned appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation?	☐	☐
6.	Have you ever had your status as a participating provider revoked, suspended, restricted, or terminated by any health plan for reasons related to clinical competence or professional conduct?	☐	☐
7.	Have you ever been convicted or, entered a plea of guilty or no contest to any felony or misdemeanor related to professional practice?	☐	☐
8.	Have you ever been convicted or, entered a plea of guilty or no contest to any felony or misdemeanor related to use and/or prescription of alcohol, controlled substances, or illegal drugs?	☐	☐
9.	Have you ever been convicted or, entered a plea of guilty or no contest to any felony or misdemeanor related to insurance or health care fraud or abuse, or violence?	☐	☐
10.	Do you have current professional liability insurance of at least $1/$3Million?	☐	☐
	Skip Questions 11-13 if you are an APN or PA		
11.	Will you be available in time and proximity to fulfill your Medical–Dental Staff responsibilities to provide timely and continuous care for your ChristianaCare patients?	☐	☐
12.	Do you have appropriate coverage arrangements with other member(s) of the ChristianaCare Medical-Dental Staff, in the same specialty, with privileges likely to be needed to provide coverage of your ChristianaCare patient when you are unavailable?	☐	☐
13.	Do you agree to perform responsibilities regarding emergency call?	☐	☐

Please note: Any positive response items 1-9 or a negative response to items 11-13 will require an explanation and an application for a waiver.

☐ I am requesting **Attending Category**

☐ I am requesting **Dental Category**

☐ I am requesting **Ambulatory Category** (membership only, no clinical privileges)

☐ I am requesting **Affiliate Category** (Psychologist, Podiatrists)

☐ I am requesting **Locum Tenens Category**

☐ I am requesting **Pediatric Courtesy Category** (Nemours Providers only)

☐ I am requesting **Telemedicine, Teleradiology or Telederm Category**

Please provide the name of a covering provider on ChristianaCare's active Medical-Dental Staff.:

____

☐ I am requesting Advanced Practice Clinician Privileges (APRNs, PAs)

Please provide the name of a collaborative/supervising provider on ChristianaCare's active Medical-Dental Staff.:

____

I hereby attest that all information submitted in this Pre-Application for membership and/or clinical privileges is true to the best of my knowledge and belief. I fully understand that any significant misstatement in or omission fromthis pre-application may result in denial of an application.

I understand that in the event this request is denied, I will not receive an application for appointment. I further acknowledge that denial of this Pre-Application does not constitute a professional review action reportable to theState or the National Practitioner Data Bank. I also understand that I will not be entitled to a fair hearing or appeal under the ChristianaCare Medical-DentalStaff Bylaws.

______________________________________ ____________

Applicant's Name Date

Application Fees are Non-refundable.

Attending, Affiliate, Ambulatory Categories - $200 APN/PA - $100

Fee is waived for employees of ChristianaCare and Residents/Fellows of ChristianaCare who have graduated within the past two years.

Please include a current CV including month/year when submitting your form.