



Dear Doctor:

Thank you for your interest in LibertyHealth and Medical-Dental Staff membership. Enclosed is a New Appointment Application package with instruction sheet for membership and privileges.

To begin the process of your application, please submit all of the requested documentation listed on the attached checklist for consideration. The Medical-Dental Staff Office will make initial requests for verification of information. If replies are not received within a reasonable period of time, you will be notified for necessary follow-up of outstanding information.

Within three (3) months from the date of receipt of application, all documents must be submitted for review by the Credentials Committee.

If you have any questions or need assistance, please do not hesitate to contact the Medical-Dental Staff Office at 201-915-2505. The office personnel are always available to work with you as you complete the application process.

Sincerely,

Tita Tobias, CPMSM, CPCS
Manager, Medical-Dental Staff Office

Enclosures

**JERSEY CITY MEDICAL CENTER
NEW APPOINTMENT APPLICATION CHECKLIST**

- One legibly completed Application form. Please include either one of the following: a Hospital Issued Photo ID, Valid picture ID issued by a state, federal, or regulatory agency e.g. driver's license, visa/passport.
- A non-refundable \$275 application fee. Please make check payable to Organized Medical-Dental Staff of JCMC.
- A completed Delineation of Privileges form approved by the Department Director and agreeable to the Applicant for each facility where privileges are requested.
- Names and complete address of 3 references listed on your application (**The named individuals must have personal knowledge, gained through clinical interaction, of your professional practice over a reasonable period of time. At least one of the references must be in the same specialty and one must have had organizational responsibility for your performance.**)
- Copy of current NJ License Registration
- Copy of current Federal Controlled Dangerous Substances Registration (DEA)
- Copy of current NJ Controlled Dangerous Substances Registration (CDS)
- Certificate of Insurance to include Liberty Health as a Certificate Holder.** Face sheet of Policy must show limit of liability and expiration of policy.
- Signed Insurance Carrier Notice
- Completed Hospital Insurance Application form for full time and part time salaried physicians
- If certified in BCLS, ACLS, ATLS, PALS, submit copies of Certification
- Proof if you are Board Certified or Board Admissible
- Proof of Practitioner's Medical School Diploma
- Copy of ECFMG Certificate, if foreign medical graduate
- Proof of completed Residency/Fellowship Training Program
- Health Status Certificate/TB Test Documentation (New Jersey State Regulation)
- Signed Authorization for Release of Information (**to include Criminal Background Check**)
- Signed Acknowledgement Receipt of Bylaws, Rules & Regulations
- Updated Curriculum Vitae
- Evidence of Continuing Medical Education



MEDICAL-DENTAL STAFF MEMBERSHIP

APPLICATION FACE SHEET AND INSTRUCTIONS

I. PRIMARY HOSPITAL SELECTION. Please check one:

- Jersey City Medical Center
- Meadowlands Hospital Medical Center

II. MEDICAL STAFF MEMBERSHIP SELECTION

Please check hospitals that you would like to request membership as well:

- Jersey City Medical Center
- Meadowlands Hospital Medical Center

III. MEMBERSHIP CATEGORY SELECTION

Please circle membership category for each facility where privileges are requested. All staff members are placed under Provisional Staff during the first year of membership at each facility. Refer to Medical-Dental Staff Bylaws regarding description of Staff Categories.

JCMC

Active
Consultant
Emeritus
LLP

MHMC

Associate
Consultant
Active
Adjunct
Emeritus
Honorary

IV. APPLICATION FEE AND DUES

- Initial Year - Application Fee & Dues in the amount of \$275 to be submitted with the application.
- Annual Staff Dues to be paid following the provisional year. Reappointment fee incorporated into staff dues.
 - Jersey City Medical Center - \$250.00
 - Meadowlands Hospital Medical Center - \$200.00

Date Received _____

Date Application Fee Paid _____



APPLICATION FOR APPOINTMENT TO THE MEDICAL-DENTAL STAFF

Place a ✓ on the hospital (s) where you are requesting appointment.

Jersey City Medical Center
 355 Grand Street
 Jersey City, New Jersey 07302
 (201) 915-2505

Meadowlands Hospital
 55 Meadowlands Parkway
 Secaucus, New Jersey 07094
 (201) 392-3228

Indicate: **Subspecialty:** _____ **Department:** _____

 Last Name First Name Middle Degree Specialty

 Primary Office Address Street City State Zip Telephone/Fax

 Secondary Office Address Street City State Zip Telephone/Fax

 Home Address Street City State Zip Telephone/Fax

PERSONAL PROFILE

Date of Birth _____	Place of Birth _____	Soc.Sec.No. _____
Citizenship/Status _____	Sex ____	Marital Status _____
Medicaid No. _____	Medicare No. _____	UPIN No. _____
National Provider Identifier: _____		ECFMG No. _____
E-mail Address _____	Beeper No. _____	Cell No. _____

EDUCATION PROFILE

(In Chronological Order)

COLLEGE/ UNIVERSITY	Name	Location	Degree	Date of Graduation

MEDICAL SCHOOLS	Name	Location	Degree	Date of Graduation

IF YOU ARE A FOREIGN MEDICAL GRADUATE, DO YOU HAVE AN E.C.F.M.G. CERTIFICATE? [] YES [] NO
 (Please provide appropriate certificate)

INTERNSHIPS AND/OR RESIDENCIES

Institution		Address	
Your Title	Inception Date	Completion Date	Program Director
Institution		Address	
Your Title	Inception Date	Completion Date	Program Director
Institution		Address	
Your Title	Inception Date	Completion Date	Program Director
Institution		Address	
Your Title	Inception Date	Completion Date	Program Director

FELLOWSHIPS OR OTHER TRAINING

Institution		Address	
Your Title	Inception Date	Completion Date	Program Director
Institution		Address	
Your Title	Inception Date	Completion Date	Program Director

TEACHING APPOINTMENTS

Location _____

Type/Area _____

Title _____

Starting Date _____

Completion Date _____

Location _____

Type/Area _____

Title _____

Starting Date _____

Completion Date _____

HOSPITAL MEMBERSHIP (List past and present hospital staff memberships. Indicate category/status and time period for each hospital listed.)

1. Hospital _____ Category _____

Address _____

Department Chairman _____

Time Period: From _____ to _____ Reason for leaving _____

2. Hospital _____ Category _____

Address _____

Department Chairman _____

Time Period: From _____ to _____ Reason for leaving _____

3. Hospital _____ Category _____

Address _____

Department Chairman _____

Time Period: From _____ to _____ Reason for leaving _____

LICENSURE (Please forward copies of valid licenses)

State	Date Issued	License #	Date of Expiration	By Examination []	By Reciprocity []

State	Date Issued	License #	Date of Expiration	By Examination []	By Reciprocity []

Federal DEA	Registration #	Date of Expiration

New Jersey CDS	Registration #	Date of Expiration

Professional Liability: Please request your malpractice insurance carrier to name Liberty Health as a certificate holder. Copy of Certificate of Insurance must show coverage amount and expiration date of the policy.

Insurance Carrier _____ Limit of Coverage _____

Special Competence Certification

Please circle any you are certified in CPR BCLS ACLS ATLS PALS NONE (And submit copy(ies) of same)

Specialty Board Certification (Please submit copy of your certification)

1. Are you Board Certified Yes [] No [] Name of Specialty Board Year Certified

2. Are you Board Admissible Yes [] No [] Name of Specialty Board Schedule of Exam

PROFESSIONAL SOCIETIES

Name: _____

Address: _____

Name: _____

Address: _____

References: Supply the names of at least three (3) professional references. The named individuals must have personal knowledge, gained through clinical interaction, of your professional practice over a reasonable period of time. At least one of the references must be in the same professional discipline and only one can be from your practice group.

Name : _____ Specialty: _____

Address: _____

Telephone No.

Name : _____ Specialty: _____

Address: _____

Telephone No.

Name : _____ Specialty: _____

Address: _____

Telephone No.

HEALTH STATUS

Are you currently experiencing any health problems, which would make you incapable of performing all responsibilities that the Medical-Dental Staff requires? Yes ___ No ___

Are you currently taking any medication that may affect either your clinical judgment or motor skills? Yes ___ No ___

Are you currently under any limitations concerning your activities or workload? Yes ___ No ___

Please read and sign this statement if it is correct:

"I know of no current personal health problems such as a communicable disease, substance abuse, physical disability or mental disorder that will interfere with my ability to practice my medical/dental specialty. I further attest to the veracity of my response."

Signature

Date

NOTE: Please attach completed Health Status Verification form included in the package.

PROFESSIONAL HISTORY

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES", PLEASE GIVE FULL DETAILS ON SEPARATE SHEET OF PAPER.

- a. Have you been named as a defendant in any criminal proceedings ? Yes ___ No ___
- b. Has your membership or clinical privileges been voluntarily or involuntarily suspended, diminished, revoked, or not renewed at any hospital or health care facility? Yes ___ No ___
- c. Have you voluntarily requested limitation, reduction, or restriction of clinical privileges or have you voluntarily resigned your appointment at any other hospital or institution? Yes ___ No ___
- d. Has your license to practice your profession in any jurisdiction been voluntarily or involuntarily limited, suspended, revoked, denied, subjected to probationary conditions or relinquished; or have challenges or proceedings toward any of those ends ever been instituted? Yes ___ No ___
- e. Has your Drug Enforcement Agency or other controlled substances authorization ever been denied, revoked, suspended, reduced, relinquished, or not renewed; or have proceedings toward any of those ends ever been instituted? Yes ___ No ___
- f. Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health insurance program, (for example, Medicare, Medicaid)? Yes ___ No ___
- g. Has your present malpractice insurance carrier excluded any specific procedures from your coverage? Yes ___ No ___
- h. Have any malpractice suits been filed against you, which are presently pending? Yes ___ No ___
- i. Have any judgments or settlements been made against you in malpractice cases? Yes ___ No ___
- j. Has any insurance carrier placed any limitations on your scope of practice? Yes ___ No ___
- k. Have you voluntarily changed your scope of practice with your insurance carrier? (e.g. Major surgery vs. Minor surgery) Yes ___ No ___
- l. Has any restriction, limitation or supervision been required by any other state agency other than New Jersey? Yes ___ No ___

DECLARATION

I, the undersigned, attest that I have to the best of my knowledge and judgment truthfully answered every question on this application. I fully understand that any deliberate mis-statement of the truth to any question on this application will constitute cause for immediate denial of my appointment or cause for my summary dismissal from the Medical-Dental Staff of LibertyHealth.

In making this application for appointment to the Medical-Dental Staff of this hospital, I acknowledge my obligation to provide continuous care and supervision of my patients. I acknowledge receipt of, have read and agree to abide by the current Bylaws, Rules and Regulations of the Medical-Dental Staff and the governing body of LibertyHealth. I further agree to be bound by the terms thereof if I am granted membership and clinical privileges.

By applying for appointment to the Medical-Dental Staff I hereby signify my willingness to appear for interviews in regard to my application. I hereby authorize the hospital, its medical staff and their representatives to consult with administrators and members of the medical staff of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby

further consent to the inspection by the hospital, its medical staff and its representatives of all documents, including medical records at other hospitals, that may be relevant to any evaluation on my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethics for staff membership.

I hereby release from liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the hospital, or its medical staff, in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff membership and clinical privileges, and hereby consent to the release of such information.

I understand and agree that I, as an applicant for Medical-Dental Staff membership and privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

I specifically pledge that I will not receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services.

Signature of Applicant

Date

Attach A Recent Photograph



**THIS SECTION IS NOT TO BE FILLED BY APPLICANT
(FOR HOSPITAL USE ONLY)**

APPOINTMENT RECOMMENDATION:

RECOMMENDED

NOT RECOMMENDED

DEFERRED

Explain (if deferred or not recommended)

APPOINTMENT TO:

PROVISIONAL

EMERITUS

ACTIVE

CONSULTANT

LIMITED LICENSED PRACTITIONER

WITH PRIVILEGES IN THE DEPARTMENT OF _____

DATE: _____

SIGNATURE: _____

Division Chief

DATE: _____

SIGNATURE: _____

Department Director

	APPROVED	NOT APPROVED	DEFERRED	DATE
CREDENTIALS COMMITTEE				
MEDICAL EXECUTIVE COMMITTEE				
BOARD OF TRUSTEES				