

Date Received: \_\_\_\_\_

Date Application Fee Paid: \_\_\_\_\_



**APPLICATION FOR APPOINTMENT TO THE MEDICAL-DENTAL STAFF**

**Jersey City Medical Center**  
50 Baldwin Avenue  
Jersey City, New Jersey 07304  
(201) 915-2505

**Greenville Hospital**  
1825 Kennedy Boulevard  
Jersey City, New Jersey 07305  
(201) 547-6117

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

\_\_\_\_\_  
Last Name                                      First Name                                      Middle                                      Degree                                      Specialty

\_\_\_\_\_  
Primary Office Address                      City                                      State                                      Zip                                      Telephone/Fax

\_\_\_\_\_  
Secondary Office Address                      City                                      State                                      Zip                                      Telephone/Fax

\_\_\_\_\_  
Home Address                                      City                                      State                                      Zip                                      Telephone/Fax

**PERSONAL PROFILE**

Date of Birth: _____	Place of Birth: _____	Sec. Sec. No.: _____
Citizenship/Status: _____	Sex: _____	Marital Status: _____
Language: _____	Medicaid No.: _____	Medicare No.: _____
UPIN No.: _____	Email Address: _____	Beeper No.: _____
ECFMG No. _____		

**EDUCATION PROFILE**

(In Chronological Order)

COLLEGE / UNIVERSITY	Name	Location	Degree	Date of Graduation

MEDICAL SCHOOLS	Name	Location	Degree	Date of Graduation
				MD
	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

**INTERSHIPS AND/OR RESIDENCIES**

Institution Christ Hospital		Address Jersey City, NJ	
Your Title	Inception Date	Completion Date	Program Director
Institution		Address , NJ	
Your Title	Inception Date	Completion Date	Program Director
Institution Kings County Hospital		Address Brooklyn NY	
Your Title	Inception Date	Completion Date	Program Director
Institution Kings County Hospital		Address Brooklyn, NY	
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 for each hospital listed. Included time period for each hospital listed.)

1. Hospital \_\_\_\_\_ Category \_\_\_\_\_  
 Address \_\_\_\_\_  
 Department Chairman \_\_\_\_\_  
 Reason for leaving \_\_\_\_\_

2. Hospital \_\_\_\_\_ Category \_\_\_\_\_  
 Address \_\_\_\_\_  
 Department Chairman \_\_\_\_\_  
 Reason for leaving \_\_\_\_\_

3. Hospital \_\_\_\_\_ Category \_\_\_\_\_  
 Address \_\_\_\_\_  
 Department Chairman \_\_\_\_\_  
 Reason for leaving \_\_\_\_\_

**LICENSURE** (Please forward copies of valid licenses)

State	Date Issued	License #	Date of Expiration	By Examination [ ]	Reciprocity [ ]
Federal DEA	Registration #	Date of Expiration			
New Jersey CDS	Registration #	Date of Expiration			

**Professional Liability:** Please request your malpractice insurance carrier to name Meadowlands Hospital Medical Center 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 \_\_\_\_\_  
 American Board of Obstetrics & Gynecolog

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 proceeding?	Yes	No
b) Has your membership or clinical privileges ever 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 ever 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.) Have any limitations been placed on your scope of practice with your insurance carrier?	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 ethical qualifications 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, and 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

**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)

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APPOINTMENT TO:

ACTIVE

PROVISIONAL

ADJUNCT

HONORARY

CONSULTANT

ASSOCIATE

COURTESY

WITH PRIVILEGES IN THE DEPARTMENT OF \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

Division Chief/Collaborating Physician

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

Department Director

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



**APPOINTMENT INFORMATION**

**CLAIMS/LITIGATION HISTORY**

**PLEASE ANSWER EACH OF THE FOLLOWING.  
If you have no claims please write "0" in the space provided.**

**PLEASE PROVIDE THE FOLLOWING INFORMATION:**

**TOTAL**

Number of Pending Professional Liability Claims or Litigation	_____
Number of Professional Liability Claims or Litigation settled with Payment of Indemnity	_____
Number of Claims Closed without Indemnity Payment	_____

**PLEASE PROVIDE DETAILS AS OUTLINED BELOW IF APPLICABLE OR PROVIDE THE EXPLANATION ON SEPARATE SHEET OF PAPER**

Name of Case: \_\_\_\_\_  
Date of Loss: \_\_\_\_\_  
Docket Number: \_\_\_\_\_  
Indemnity Paid: \_\_\_\_\_

Brief Summary: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Practitioner Name: \_\_\_\_\_  
Type/Print Name  
\_\_\_\_\_  
Signature  
\_\_\_\_\_  
Date  
\_\_\_\_\_



Dear Insurance Carrier:

Please be advised that practitioner \_\_\_\_\_ has presented documentation of malpractice coverage through your company.

\_\_\_\_\_ practices at the following facility under LibertyHealth

- Jersey City Medical Center (JCMC)**
- Greenville Hospital (GH)**
- Meadowlands Hospital Medical Center (MHMC)**

and is subject to the Bylaws, Rules and Regulations of the Medical-Dental Staff, which require that the practitioner carry appropriate liability insurance coverage.

This letter is to request that you make the necessary arrangements to notify the above facility(ies) immediately should there exist any lapse, termination or exhaustion of policy limits, in order that we may take appropriate action to protect the interest of LibertyHealth and its patients.

Sincerely,

Brenda Shaw, CPCS  
Director, Medical Staff Services

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_ insurance carrier, to provide LibertyHealth with a certificate of insurance for my professional liability coverage on an annual basis. The COI must list **Meadowlands Hospital Medical Center as the Certificate Holder**. In the event of any material change in, cancellation of, or failure to renew said policy, I also authorize the above named company to give written notice to LibertyHealth. I hereby release from liability such insurance company and its representatives that provide this information and agree to hold them harmless from any action by me for their acts.

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print or Type Name

**Meadowlands Hospital Medical Center, 55 Meadowlands Parkway, Secaucus, NJ 07096  
Phone: 201-392-3228 – Fax: 201-392-3526**



**HEALTH STATUS VERIFICATION**

I have examined \_\_\_\_\_ and have found him/her to be free from any health impairment that would pose a potential risk to patients and hospital personnel or which might interfere with performance of his/her duties.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

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

**NOTE TO APPLICANT: TO BE COMPLETED BY A PHYSICIAN OTHER THAN YOURSELF.**



**PHYSICIAN DATA FORM**

Physician ID #: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Specialty: \_\_\_\_\_ Sub Specialty: \_\_\_\_\_

Office Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Medicare #: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

UPIN #: \_\_\_\_\_

NPI #: \_\_\_\_\_

Physician Signature: \_\_\_\_\_



**AUTHORIZATION AND CONSENT**

Applicant: \_\_\_\_\_

By applying for appointment or reappointment to the Medical Staff, I hereby indicate my willingness to appear for interviews in regard to my application, and I hereby authorize LibertyHealth, the Hospital, its Medical Staff and their representatives to consult with others who may have information bearing on my competence and qualifications, including hospital executive and members of the Medical Staff of other hospitals or institutions with whom I have been associated, past and present malpractice insurance carriers, and any other individuals who may have information bearing upon my competence, character and ethical qualification. I hereby consent to the inspection by LibertyHealth, the hospital, its Medical Staff and its representatives of all records and documents that may be material to an evaluation of my professional qualifications, ethics and competence to carry out the clinical privileges requested, as well as my medical qualifications for staff membership. I understand that as part of this inspection, the hospital may obtain information from other agencies verifying eligibility to participate in federal and other governmental programs, either as part of my credentialing or at any time while I am a Member of the Medical Staff. Information obtained may include the status, background and circumstances of my participation in any federal, state, or other governmental payer program and may include information concerning, my application to, participation in or disqualification from any such program.

By my signature below, I acknowledge that I have read and I understand the foregoing disclosure. I hereby release from liability any and all individuals and organizations who provide information to LibertyHealth, the Hospital and its Medical Staff, in good faith and without malice, concerning my professional competence, ethics, character, and other qualifications for Medical Staff appointment or reappointment and clinical privileges, and I consent to the release of such information to LibertyHealth, Meadowlands Hospital Medical Center and its Medical Staff to other Hospitals, Medical Associations and appropriate persons on request regarding any information the Hospital and the Medical Staff may have concerning me, as long as such release of information is done in good faith and without malice, and I release from liability LibertyHealth, this Hospital and its Medical Staff and there employees and agents for doing so.

Date \_\_\_\_\_

Signature \_\_\_\_\_

Print Name: \_\_\_\_\_



**PHYSICIAN ACKNOWLEDGEMENT**

“Notice to all Physicians: Medicare payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested by the patient’s attending physicians by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.”

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Signature – Full Name

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Typed or Printed Name

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Date of Signature



**BYLAWS ATTESTATION**

I hereby acknowledge receipt of the Bylaws, Rules and Regulations of the Medical Staff of

- Jersey City Medical Center (JCMC)
- Greenville Hospital (GH)
- Meadowlands Hospital Medical Center (MHMC)

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Department

\_\_\_\_\_  
Date



**Meadowlands Hospital Medical Center  
Medical Staff  
Education and Orientation Manual**

**Quality/Risk Management**

- Mission
- Plan for Provision of Care
- Risk Plan Policy
- LHS Compliance Program Policy
- Practical Issues for Physicians in Disclosing Unanticipated Outcomes

**Patient Rights**

- Restraints
- DNR
- Advance Directives
- Bioethics/Informed Consents
- Admission and Discharge of Patients from the ED

**Occupational/ Environmental Safety**

- RACE, PASS.
- MHMC Codes
- Physician role in External Disaster
- Physician role in Evacuation

**Blood / Blood Components**

- Transfusion Forms
- Blood Transfusion Policy

**Pharmacy/ Therapeutics**

- ADR Policy & Procedure
- ADR Self Assessment Module

**Abuse/Neglect**

- Child Abuse/Neglect
- Alleged Sexual Assault Victim (rape)
- Identification of Geriatric or other victim of abuse

**Infection Control**

- Isolation signs – CDC guidelines/contact resistant organisms
- Basic Hand washing

**EMTALA**

- EMTALA Overview
- Frequently Asked Questions
- The 20 Commandments

I have read the enclosed policy and statements

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_



## **COMMUNICATIONS POLICY**

All of us at LibertyHealth take pride in the strides we have made to improve patient care, our buildings and our work environment. We want the community to know about it, but communicating change to the public is not easy. We are acting on it through new stories, TV interviews, newsletters, advertising and direct community contacts, but there is much more to be done. And all of us must help.

Each of us is part of the story and part of the storytelling, too. The work we do and everything we say about LibertyHealth, each of our three hospitals and our other affiliates is important. Good words build understanding and confidence. Negative words tear them down. As a result, all of us who serve as staff or trustee have an obligation to serve with pride and to tell about it. We are a team. And when there is a problem, we have an obligation to bring it to the attention of our teammates so that it can be addressed. It is wrong to take it to the media or otherwise act in the community to tear down what takes years to build. This is a violation of rules at most good organizations and it is a violation of rules at every LibertyHealth affiliate.

To help make everyone's rights and obligations clear, the LibertyHealth Board of Trustees has established the following communications policies for itself, each affiliate and all staff.

1. Patient confidentiality is absolute. No information regarding patients should ever be shared with the media or anyone else, other than the immediate family. Requests for information should be referred to the pertinent CEO's office.
2. Personal attacks by any staff member or trustee is unacceptable. They will result in the disciplinary action described below.
3. Neither trustees nor staff are authorized to initiate a contact with the media or respond to a media inquiry about hospital or affiliate affairs. Prior notice and approval by CEO's office are required in the case of staff and the Chairman of the pertinent board in the case of trustees.
4. A staff member who believes activities or conditions at his or her hospital or agency require attention and remediation should notify supervisors or the appropriate vice president or senior vice president. If the staff member believes confidentiality is required, he or she may bring the concern directly to LibertyHealth's outside attorney, who will review it with the Chairman of the Board. Confidentiality and job protection are guaranteed. The attorney is Zulima Farber, Esquire, Lowenstein, Sandler, 65 Livingston Avenue, Roseland, NJ 07068. Telephone: 201-992-8700.

A trustee who has information regarding such activities or conditions is obliged by his or her trusteeship to bring it directly to the attention of their respective Board and if dissatisfied with resultant Board action, is obliged to resign his or her trusteeship prior to making public statements, at which time that person is free of his or her obligation to adhere to this communication policy.

5. Staffs who fail to adhere to the Communications Policy are subject to disciplinary action up to and including termination. In the case of trustees who fail to adhere to the Communications Policy, such failure will be considered when a trustee is reviewed for renomination to the Board. In serious cases, the Board may choose to take immediate action such as suspension or removal.
6. Any Staff member or trustee who believes he or she cannot abide by the policies stated above may, in good conscience, resign their position without adverse effect. In the case of staff, the hospital or other affiliate shall not record any negative comment in personnel records and shall not allow such resignation to affect references and recommendations for subsequent employment or appointment elsewhere.

In sum, it is a condition of employment or appointment at Jersey City Medical Center, Greenville Hospital, Meadowlands Hospital Medical Center, or any other LibertyHealth affiliate to communicate with each other and the public, when required, in a positive manner and to desist from public statements that damage the reputation of LibertyHealth or each other. If in doubt as to the meaning of this policy, or any matters relating to communication, contact the LibertyHealth Office of Public Affairs at 201-915-2040. It is the job of that office, directed by William Dauster, to provide balance, accurate information to the public and to help all of us do the same.