Boulder Community Hospital
Medical Staff

COMMUNITY BASED MEMBERSHIP
(WITHOUT CLINICAL PRIVILEGES)

RENEWAL APPLICATION

Submit by _____
(date)

Name: _____ **Specialty:** _____

☐ I request to renew my membership with Medical Staff of Boulder Community Hospital. I understand this category allows me to order non-invasive outpatient diagnostic tests and services, visit patients in the hospital, review medical records and write courtesy notes. I am not eligible for clinical privileges and do not admit or manage patient care in the hospital.

☐ I do NOT request to renew my membership with the Medical Staff of Boulder Community Hospital and, in affixing my signature below, attest that I fully understand that my current Medical Staff membership and at Boulder Community Hospital *will expire at the end of my current appointment*.

Signature: _____ **Date:** ___ _____

IF REQUESTING RENEWAL, PLEASE COMPLETE THE FOLLOWING. ATTACH ADDITIONAL SHEETS AS NECESSARY.

CONTACT INFORMATION
PRACTICE NAME: _____
ADDRESS: _____
PHONE: _____ **FAX:** _____
HOME ADDRESS: _____ **DOB:** _____
PHONE: _____ **CELL:** _____ **EMAIL:** _____

PROFESSIONAL REFERENCES	
Provide the names and addresses of at least 2 peers who have had recent extensive experience in observing or working with you who can provide information pertaining to your present clinical competence, character, and ability to work as a member of the healthcare team. These peers must share the same professional credentials as you. None of these individuals are to be related to your family, or have current or impending professional or financial associations with them or you.	
Reference	**Address/Phone and fax**
1.	
2.	
3.	

Hospital/Employment Affiliations	Dates	Status	Department/Specialty

LICENSURES State	Status	Expiration	Comments

INSURANCE COVERAGE	
Current Coverage:	
Policy Number:	
Retroactive to:	
Current Period:	
Limits:	

PROFESSIONAL LIABILITY CLAIMS HISTORY

In the past two years, has any professional liability insurance carrier ever:

1. Terminated your coverage by action of their company? ☐ Yes ☐ No
2. Not renewed your coverage by action of their company? ☐ Yes ☐ No
3. Denied you professional liability insurance coverage? ☐ Yes ☐ No

If the answer to any of the above questions is **YES**, on a separate piece of paper state the date of the action and describe the circumstances. Attach each explanation to this application.

Have you had any claims asserted against you during the past two years? ☐ **Yes** ☐ **No**

I If the answer to any of the above questions is **YES**, on a separate piece of paper state the date of the action and describe the circumstances. Attach each explanation to this application.

You must answer each of the following questions. For each YES answer you are required to provide a full explanation on a separate sheet of paper and attach it to this application. ***In the last 24 months:***	**YES**	**NO**
Has your professional license, or any other license or registration, been successfully or unsuccessfully challenged, or are there any pending/threatened challenges to any license held by you?		
Has any of the aforementioned licensure or registration, been voluntarily or involuntarily relinquished, or has your license to practice in any jurisdiction been denied, limited, suspended, or revoked?		
To your knowledge, have you been the subject of any report(s) to a state or federal data bank or state licensing or disciplining entity?		
Have you been named as a defendant in any criminal proceeding?		
Has there been a successful or unsuccessful challenge to any controlled substance or narcotics license granted to you by a State or Federal government agency, or is there currently any pending or threatened challenge to any such licensure?		
Have you ever voluntarily or involuntarily relinquished any controlled substance or narcotics license, or has any such license been revoked, suspended, or denied, or have you been the subject of an investigation regarding any such license?		

Have you been denied membership on the staff of any hospital or health care facility, or has your membership been voluntarily or involuntarily terminated?		
Have you been subject to disciplinary action regarding your membership at any hospital or health care facility, or is there any pending or threatened disciplinary action regarding any such membership?		
Have you been denied clinical privileges at any hospital or healthcare facility, or has there been a termination or limitation, voluntary or involuntary, of any of your clinical privileges?		
Have your clinical privileges been challenged or continued on a probationary basis?		
Have you been the subject of probation or other sanction at any hospital or health care facility for any reason?		
Have you been denied membership or had a voluntary or involuntary suspension or termination of your membership in any professional society?		
Have there been any challenges, successful or unsuccessful, to your certification by any specialty board, or are there any pending challenges to your certification by any specialty board?		
Has any regulatory agency ever challenged or threatened to challenge your right to practice, or are any challenges pending that would affect your right to practice?		
Have you been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (PHP, Medicare, Medicaid, etc.)?		
Have you been the subject of any investigation by any private, federal, or state agency concerning your participation in any private, federal or state health insurance program?		
Has your license to practice any profession other than medicine, dentistry, or podiatry been limited, suspended, or revoked, or have you ever been denied such a license?		
Is there any proceeding pending or threatened against you, which if decided adversely to you, would require you to answer yes to any of the preceding questions?		

FOR MEDICAL STAFF OFFICE USE ONLY

Provider Name:_____

	Verified	Date
License		
OIG/Excluded Parties		
Malpractice Insurance		
NPDB		

Therefore, I find this applicant:

- ❑ Qualified for membership as, community based, to the Medical Staff.
- ❑ Qualified for membership as community based, to the Medical Staff with the following conditions or Exceptions:
- ❑ Not qualified for membership for, community based, to the Medical Staff.

Department Chair Signature:_____Date: _____

Consent and Release

I hereby apply for membership as requested above. As an applicant, I have the burden of producing adequate Information for proper evaluation of my application. As a condition to submitting this application, any misrepresentation or misstatement in, or omission from this application, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application. In the event that your membership has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of such membership.

By applying for membership, I accept the following conditions during the processing of my renewal application, regardless of whether or not I am granted membership, and for the duration of such as I may be granted:

a) I extend absolute immunity to, and release from any and all liability, the hospital, its authorized representatives and any third parties, as defined in subsection (b) below, for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, performed, made, requested or received by Boulder Community Hospital and its authorized representatives to, from, or by any third party, including otherwise privileged or confidential information. This information shall be privileged to the fullest extent permitted by law. Such privilege shall extend to the hospital and its authorized representatives, and to any third parties.

b) I specifically authorize the Boulder Community Hospital and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on my satisfaction of the criteria for initial and continued membership, as well as to inspect or obtain any and all communications, reports, records, statements, documents (including claims histories), recommendations or disclosures of said third parties relating to such questions. I also specifically authorize said third parties to release said information to the hospital and its authorized representatives upon request.

c) I specifically agree to abide by all such bylaws, policies, directives and rules and regulations as are in force. I specifically agree to: (1) refrain from delegating responsibility for diagnoses or care of hospitalized patients to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised; (2) refrain from deceiving patients as to the identity of any practitioner providing treatment or services; (3) seek consultation whenever necessary or required; (4) abide by generally recognized ethical principles applicable to my profession; (5) provide continuous care and supervision as needed to all patients in the hospital for whom I have responsibility.

d) I agree I will participate in the Organized Health Care Arrangement ("OHCA") established by Boulder Community Hospital and to facilitate the sharing of patients' medical information for purposes of treatment, payment and health care operations of the OHCA in accordance with the privacy regulations promulgated under HIPAA. I agree to comply with the Hospital's Privacy Policies and to abide by the terms of the Joint Notice of Privacy Practices. I understand that the Joint Notice only applies to care provided at the Hospital and that I must provide patients with a separate notice for care provided outside the Hospital.

I acknowledge that I may be in possession of information that is considered strictly confidential and is protected from disclosure by both state and federal laws. I agree to maintain the confidentiality of all information, which comes into my possession during the course of my membership at Boulder Community Hospital.

_____ _____

SIGNATURE OF APPLICANT DATE

_____

PRINTED OR TYPED NAME