APPLICATION

FOR

APPOINTMENT

TO THE

MEDICAL STAFF

OF

ST. JUDE HOSPITAL

GENERAL Complete the application in full. **Print or type all responses.**

INSTRUCTIONS Attach additional sheets if there is insufficient space on this form to complete your response

PERSONAL INFORMATION

_______________________________ M.D. D.O. D.D.S. OTHER
Name in full

Office Address No.& Street City State Zip

Home Address No.& Street City State Zip

Office Tel. Home Tel. Date and place of birth

Contact in Case of Emergency:

Name Relationship

Address Telephone

Current Citizenship

PROFESSIONAL PRACTICE (begin with current association)

Nature of Practice and Principal Associate (Solo, Partnership, Group)	Office Address	Inclusive Dates
		to
		to
		to

INTENDED DATES OF SERVICE: ______________________________

ACCOMPANIED BY:______________________________

B1

PRIMARY CLINICAL Please indicate the Department to which you are requesting appointment ______________________________

AFFILIATION REQUESTED

__________ Anesthesiology ________Obstetrics/Gynecology
__________ Cardiovascular Med.________Ophthalmology
__________ and Surgery
__________ Dental & Oral Surg.________Orthopedics
__________ Emergency ________Otolaryngology
__________ Family Practice ________ Pathology
__________ Gen. Surgery ________ Pediatrics
__________ Internal Medicine ________ Plastic Surgery
__________ Neurology/Psychiatry______ Radiology
__________ Neurosurgery ________ Urology
__________ Other

EDUCATION
UNDERGRADUATE School Name/Location ____________________________________

Major__________________Degrees:_________Attended From:________To:_______________

School Name/Location ____________________________________

Major _________________Degrees:_________Attended From:________To:_______________

School Name/Location____________________________________

Major_________________Degree:__________ Attended From: _______To: _______________

School Name/Location ____

Major __________________Degree________Attended From_______To:__________________

OTHER
GRADUATE School Name/Location ____

Major_____________________Degrees:_________Attended from: ______To:______________

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GRADUATE MEDICAL
TRAINING
INTERNSHIP Institution Name/Location ____

Specialty______________From______To:_____Successfully Completed: Yes/No

RESIDENCIES Institution Name/Location _______________________________________

Specialty____________From_______To:______Successfully Completed: Yes/No

Institution Name/Location _______________________________________

Specialty ___________From_______To:______Successfully Completed: Yes/No

If you have not completed your residency, please give the name, address and telephone number of the Chairman of the Residency Program:

FELLOWSHIPS/ RECEPTORSHIPS Institution Name/Location _______________________________________

Specialty_____________Fr:_____To:______Successfully Completed: Yes/No

Institution Name/Location ________________________Tel.#_________ ______

Specialty________From_____To______Successfully Completed: Yes/No

CURRENT LICENSURE COUNTRY/STATE NUMBER CURRENT? BY?

Exam_______Reciproc_______Yes___No_____

Exam______Reciproc________Yes___No_____

Exam______Reciproc________Yes___No____

Exam______Reciproc________Yes___No____

Exam______Reciproc________Yes__No_____

Exam______Reciproc________ Yes___No____

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DRUG ENFORCEMENT
ADMINISTRATION NUMBER _________________ Expiration Date __________________

(Federal)

BOARD CERTIFICATION	Board Name	Certified	Recertified	Status & Year Qualified for Exam (until when)
	________________	_________	____________	_________________________
	________________	_________	____________	_________________________
	________________	_________	____________	_________________________

HOSPITAL AFFILIATIONS	Name & Location	Tel. #	Dept/Service	Inclusive Dates
	___________________	___________________	______________	________________
	___________________	___________________	______________	________________
	___________________	___________________	______________	________________
	___________________	___________________	______________	________________
	___________________	___________________	______________	________________

OTHER INSTITUTIONAL	Name	Location	Nature of Affiliation	Affiliation Inclusive
Include Military	_______________	_____________	________________	_________to______
	___________	_____________	_____________________	________to______
	_____________	_____________	___________________	________to______
	__________________________		____________________	________to______

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List all present and prior in chronological order, beginning with most recent.

School Title Inclusive Dates

ACADEMIC APPOINTMENTS ____________________________ _____________ ______to_______

____________________________ _____________ ______to_______

____________________________ _____________ ______to_______

DISCIPLINARY ACTIONS

Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed or voluntarily relinquished? If yes, please provide full explanation on a separate sheet.

Medical license in any state...................... Yes ___ No ___
Other professional registration/license........ Yes ___ No ___
DEA registration..................................... Yes ___ No ___
Academic appointment............................ Yes ___ No ___
Appointment to any hospital medical staff.... Yes ___ No ___
Clinical privileges...................................... Yes ___ No ___
Prerogatives/rights on any medical staff....... Yes ___ No ___
Other institutional affiliation or status........... Yes ___ No ___
Professional society membership/fellowship Yes ___ No ___
Board certification........................... Yes ___ No ___
Professional office........................... Yes ___ No ___
Any other type of professional sanction........ Yes ___ No ___
Professional liability insurance.............. Yes ___ No ___
Have there been any felony criminal charges
brought against you in the last 5 years?....... Yes ___ No ___
If Yes, please provide full explanation on
separate sheet, including resolution of charges.

HEALTH STATUS

If any of the following questions are answered in the affirmative, please provide full explanation on separate sheet.

Do you presently have a physical or mental health condition, including alcohol or drug dependence, that affects or is reasonably likely to affect your ability to perform professional or medical staff duties appropriately?

Yes____No____

Are you currently under care for a continuing health problem?

Yes____No____

PUBLICATIONS

Attach your current bibliography to this application, including major professional offices you have held or committees on which you have served during the last five years.

PROFESSIONAL REFERENCES

Name three physicians who have personal knowledge of your current clinical abilities, ethical character, health status, and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from the Hospital and Medical Staff authorities. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reason able period of time and, at least one, must have had organizational responsibility for your performance.

(Requested sources: Chief of residency training program, department chairman/service chief, practitioners in same specialty.)

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Name Street No. City State Zip

____

Name Street No. City State Zip

____

Name Street No. City State Zip

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I agree to abide by the Medical Staff Bylaws, Rules and Regulations of the Medical Staff or other regulations of St. Jude Hospital and such rules as may from time-to-time be enacted.

I agree to the review of the Quality of Medical Care in the manner prescribed and promulgated by the Medical Staff and the Hospital Board of Directors.

If in verifying information, or if any information comes forward, there is or has been an omission of information or false statements crucial to the application, any privileges granted to the applicant may be terminated.

This application is complete only when all information has been received and verified and will not be processed until such time.

______________________________ ____________________
Signature of Applicant **Date**

OFFICIAL USE ONLY

APPROVED	DISAPPROVED	DATE
__________	_________	_________
__________	_________	_________
__________	_________	__________

Privileges in: ______________________________

Restrictions, if any: ____________________________________

Administrator____________________ Date:__________________

Medical Director___________________Date:__________________

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