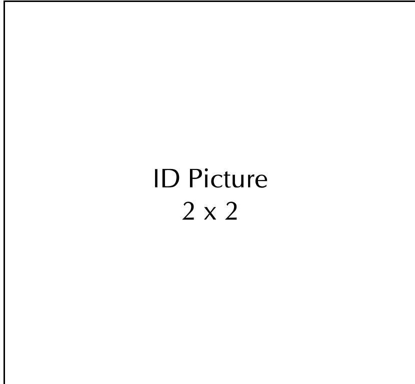
CARDINAL SANTOS
MEDICAL CENTER

MEDICAL STAFF APPLICATION FORM

MED-03-041-01



INSTRUCTIONS:

1. Please type or PRINT clearly
2. All questions must be answered completely.

STATUS APPLIED

- ☐ ACTIVE
- ☐ ASSOCIATE
- ☐ VISITING

PERSONAL DATA

Last Name		First Name	Middle Name	
Date of Birth (Month/ Day/ Year)		Place of Birth		
Specialty		Subspecialty	Degree	
TIN	GSIS/SSS #	PhilHealth Accreditation Number	Expiration Date (Month/ Day/ Year)	
Home Address			Telephone Number	
Email Address		Mobile Number	Fax Number	
Office Address			Telephone Number	Fax Number
Provincial Address			Telephone Number	Fax Number
Marital Status ☐ Single ☐ Married ☐ Annulled ☐ Separated ☐ Widowed			If MARRIED, Spouse's Name	
Other Languages Spoken			Citizenship	

LICENSE(S) FOR PRACTICE

(Copy of licenses must be included with this Application)

	LICENSE NUMBER	YEAR ISSUED	EXPIRATION DATE
PRC			
S2			

Name others with whom you are associated in practice:

NAME	ADDRESS	SPECIALTY

List physician(s) who will provide cross coverage when you are not available:		
NAME	ADDRESS	SPECIALTY

EDUCATION

SCHOOLS

TYPE	NAME	ADDRESS	DEGREE	DATES ATTENDED	
Masteral/Doctoral Education				From	To
Medical Education				From	To
Pre-Medicine Education				From	To

INTERNSHIPS: If more than one internship was begun or completed, please supply the same information on a separate sheet and attach.

Institution Name	Address	Zip Code
Dates Attended From To	Program Director	

RESIDENCY: If more than two residences were begun or completed, please supply the same information on a separate sheet and attach.

Institution Name	Address		Zip Code
Type of Residency	Dates Attended From To	Department Chairman or Program Director	
Institution Name	Address		Zip Code
Type of Residency	Dates Attended From To	Department Chairman or Program Director	

FELLOWSHIPS: If more than two fellowships were begun or completed, please supply the same information on a separate sheet and attach.

Institution Name	Address		Zip Code
Type of Fellowship	Dates Attended From To	Department Chairman	
Institution Name	Address		Zip Code
Type of Fellowship	Dates Attended From To	Department Chairman	

TEACHING APPOINTMENTS: If more than one teaching appointment was begun or completed, please supply the same information on a separate sheet and attach.

Institution Name	Address		Zip Code
Type of Teaching Appointment/Rank	Dates Attended From To	Department Chairman	

1. During your internship, residency, fellowship or teaching appointment (as is applicable):
   a. Were you ever disciplined, suspended, placed on probation, formally reprimanded or asked to resign? ☐ Yes ☐ No
   b. Have you had a leave for 30 or more consecutive days? ☐ Yes ☐ No

   If YES, please attach a sheet with detailed information.

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BOARD CERTIFICATION

Are you board eligible?	☐ Yes	☐ No
Are you board certified?	☐ Yes	☐ No
Has your Board Certification* ever been voluntarily relinquished?	☐ Yes	☐ No

Names of specialty boards by which you are certified:

SPECIALTY NAME	DATE CERTIFIED

HOSPITAL AFFILIATIONS

FACILITY NAME	ADDRESS	AFFILIATION STATUS	CLINIC DAYS/ HOURS	CONTACT NUMBERS

1.	Have your membership or clinical privileges ever been voluntarily or involuntarily limited, reduced, suspended, or relinquished, or have you ever lost your clinical privileges at another health care facility (e.g., hospital) or managed care organization (e.g., HMO/PPO)?	☐ Yes	☐ No
2.	Has your application for appointment to the medical staff of any other health care facility ever been denied?	☐ Yes	☐ No
3.	Have you voluntarily or involuntarily resigned from the medical staff of any health care facility?	☐ Yes	☐ No

If the answer to any of the above question is YES, please attach a sheet with detailed information.

PROFESSIONAL DATA

Please answer each of the following questions in full:

1.	Have any disciplinary actions ever been initiated and/ or are now pending against you by any licensure board?	☐ Yes	☐ No
2.	Has your license to practice medicine ever been denied, limited, suspended, revoked, placed on probation or voluntarily relinquished?	☐ Yes	☐ No
3.	Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, or government health insurance program (for example, PhilHealth or Medicare)?	☐ Yes	☐ No
4.	Have you ever been the subject of an investigation by any private or government agency concerning your participation in any private or government health insurance program?	☐ Yes	☐ No
5.	Has your PRC license ever been limited, suspended, revoked or voluntarily/ involuntarily relinquished?	☐ Yes	☐ No
6.	Have you ever been convicted of a felony or misdemeanor other than minor traffic violations?	☐ Yes	☐ No

If the answer to any of the above question is YES, please attach a sheet with detailed information.

HMO/PPO AFFILIATIONS

Name all the HMOs, PPOs, network and other managed care organizations in which you have participated in the last three years.

1. ______________________________
2. ______________________________
3. ______________________________

Identify other HMOs, PPOs, Networks or managed care organizations from which you have been dropped or denied admission (attach an explanation for each).

1. ______________________________
2. ______________________________
3. ______________________________

LEGAL ACTIONS

1.	Have any civil, criminal or professional liability claims or suits ever been filed against you?	☐ Yes	☐ No
2.	Have any civil, criminal or professional liability claims or suits ever been filed against you that are presently pending?	☐ Yes	☐ No
3.	Have any judgments been made against you in a civil, criminal or professional liability case(s) or claim(s), or have you entered into any settlements?	☐ Yes	☐ No

If the answer to any of the above question is YES, please attach a sheet with detailed information. The explanation must include: Name of court in which suit was filed; caption; name and address of attorney defending you; brief summary of all other relevant details.

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HEALTH STATUS

1.	Are you able to perform privileges requested without harm or injury to patients?		☐ Yes	☐ No
2.	Present health status: (If FAIR or POOR, state reasons on a separate sheet.)	☐ Good	☐ Fair	☐ Poor
3.	Have you been hospitalized any time during the past five years?		☐ Yes	☐ No
4.	Do you have any limitations on your health, life or disability insurance, or have you ever been denied or rated under such coverage?		☐ Yes	☐ No
5.	Have you ever had any problems with alcohol or drug dependency?		☐ Yes	☐ No
6.	Are you currently under any medication that may affect either your clinical judgment or motor skills?		☐ Yes	☐ No
7.	Are you currently under any limitations in terms of activity or work load?		☐ Yes	☐ No
8.	Are you currently under the care of a physician or psychologist?		☐ Yes	☐ No
9.	Have you ever been hospitalized for any particular condition which could impair your ability to provide patient care service for which you are seeking clinical privileges?		☐ Yes	☐ No

If the answer to any questions 3, 4, 5, 6, 7, 8 or 9 is YES, please attach a sheet with detailed information.

REFERENCES

List three professional references who have personal knowledge and can evaluate your performance, not including current partners, associates in practice or relatives. Provide current complete addresses.

NAME	ADDRESS	TELEPHONE

Signature over Printed Name (Applicant)	Date

IMPORTANT MESSAGE FROM PHILHEALTH

NOTICE TO PHYSICIANS:

PhilHealth payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major operations performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents falsifies or conceals essential information required for payment of medical claims, may be subject to fine, imprisonment or civil penalty under applicable Philippine laws.

I, ____, the undersigned, acknowledge the above notice.

_______________________________ Signature over printed name

_______________________________ Date

(Please sign and date the statement above and return it to the Medical Division, Cardinal Santos Medical Center.)

HEALTH STATUS VERIFICATION

Medical Staff Member's Name

I, ____, do attest to the above-named Physician's current mental and physical health status and declare that he/she is able to perform all clinical privileges as delineated

COMMENTS (Please note any limitations/ restrictions to be considered as relates to his/ her current medical practice).

Note: Please have this form completed by a physician other than yourself.

Attesting Physician's Signature Over Printed Name	Date Signed	License Number	Expiration Date	PTR

APPLICANT'S CONSENT, RELEASE, AND ATTESTATION

I hereby apply for medical staff appointment or reappointment and clinical privileges as requested in this application and, whether or not my application is accepted, I acknowledge, consent and agree as follows:

As an applicant for appointment or reappointment, I have the burden for producing adequate information for proper evaluation of my qualifications. I agree to update the facility with current information regarding all questions contained in this application and any additional information as may be requested by the facility or its authorized representatives. Failure to produce any such information will prevent my application from being evaluated and acted upon. I hereby signify my willingness to appear for an interview, if requested in regard to my application.

Information given in or attached to this application is accurate and complete to the best of my knowledge. I fully understand that any misrepresentations or misstatement in, or omission form it, whether intentional or not, shall constitute probable cause for rejection of this application, resulting in denial of appointment and clinical privileges.

I release from any and all liability, the facility its authorized representatives and any third parties for any acts, communications recommendations or disclosures performed without intentional fraud or malice involving me; made, requested or received by this facility and its authorized representatives to, form or by any third party, including otherwise privileged or confidential information, relating but not limited to, the following: (1) applications for appointment or clinical privileges, including temporary privileges; (2) periodic reappraisals; (3) proceedings for suspension or reduction of clinical privileges for or denial or revocation of appointment, or any other disciplinary action; (4) summary suspension; (5) hearings and appellate reviews; (6) medical care evaluations; (7) utilization reviews; (8) any other facility , medical staff, department, service or committee activities; (9) matters to inquiries concerning my professional qualifications, credentials, clinical competence, character, metal, or emotional stability, physical condition, ethics or behavior; and (10) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of this or any other facility or health care facility.

I specifically authorize the facility 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 continued appointment to the medical staff, as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations and/or disclosures of said third parties relating to such questions. I also specifically authorize said third parties to release said information to the facility and its authorized representatives upon request.

I acknowledge that (1) medical staff appointment or reappointment and clinical privileges at this facility are not a right; (2) my request will be evaluated in accordance with prescribed procedures defined in the facility and medical staff bylaws, rules and regulations; (3) all medical recommendations relative to my application are subject o ultimate action of the facility Board whose decision shall be final; (4) I have the responsibility to keep this application current by informing the facility of any change in the areas of inquiry contained wherein; (5) appointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the facility as evidenced by admission, treatment and continuous care and supervision of parties for whom I have responsibility , and acceptable performance of all responsibilities related thereto, as well as other factors that are relevant to the efficient operation of the facility . Appointment and continued clinical privileges shall be granted only on formal application according to facility and medical staff bylaws, rules and regulations, and upon final approval of the facility Board.

I understand that I have been given access to a copy of the medical staff bylaws, rules and regulations of medical staff presently in force, and I agree to abide by all such bylaws, policies, directives, rules and regulations as are in force, and as they may thereafter be amended. During the time I am appointed to the medical staff I will keep the extent of my practice at this facility in accordance with delineation of privileges granted to me. I 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 identity of any practitioner providing treatment or services; (3) seek consultation whenever necessary; (4) abide by generally recognized ethical principles applicable to my profession; (5) provide continuous care and supervision as needed to all patients in the facility/health plan for whom I have responsibility; and (6) accept committee assignment and such other duties and responsibilities as shall be assigned to me by the management of the hospital and medical staff.

______________________________ Signature over printed name (Applicant)

______________________________ Date