# CHILDREN'S NATIONAL MEDICAL CENTER
# APPLICATION FOR MEDICAL STAFF APPOINTMENT

## MEDICAL STAFF CATEGORIES (Check one)

__Attending*
__Consulting**
__Allied Doctoral Scientist
__Allied Doctoral Clinician
__Allied Health Professional
__Limited Duty
__Academic Advisory
__Community Advisory

*Admitting privileges
**Applicant must be nominated for this category by the division chief

**CANCER AND BLOOD DISORDERS:**
__Allergy and Immunology
__Anatomic Pathology
__Blood and Marrow Transplantation
__Hematology
__Oncology
__Laboratory Medicine
__Rheumatology

**COMMUNITY PEDIATRIC HEALTH**
__Adolescent Medicine/Young Adult Medicine
__General and Community Pediatrics
__Child and Adolescent Protection Center
__Dentistry
__Dermatology

**HEART, LUNG AND KIDNEY DISEASE**
__Cardiology
__Cardiovascular Surgery
__Nephrology
__ Pulmonary and Sleep Medicine

**HOSPITAL-BASED SPECIALTIES:**
__Critical Care Medicine
__Diagnostic Imaging and Radiology
__Emergency Medicine and Trauma Services
__Endocrinology
__Hospitalist Medicine
__Infectious Disease
__Neonatology
__Transport Medicine

**NEUROSCIENCE & BEHAVIORAL MEDICINE:**
__Developmental Pediatrics
__Genetics and Metabolism
__General Child Neurology
__Hearing & Speech
__Neurophysiology, Epilepsy, Neuro ICU
__Neuropsychology
__Neurosurgery
__Physical Medicine/Rehabilitation
_Psychiatry
__Psychology

**SURGICAL CARE:**
__Anesthesiology and Pain Medicine
__Gastroenterology/Nutrition
__General Surgery
__Ophthalmology
__Orthopaedic Surgery and Sports Medicine
__Otolaryngology
__Reconstructive Surgery
__Urology

**Please return the completed application to:**

**Children's Hospital, Medical Staff Office**
**12211 Plum Orchard Dr**
**Medical Staff Office Suite 310**
**Silver Spring, MD 20904**
**(301) 572-1327**

Revised: 4/15/11

# APPLICATION FOR MEDICAL STAFF APPOINTMENT

***Please Print or Type***

**ANTICIPATED START DATE:**_____

**PROFESSIONAL DESIGNATION:** (Circle all that apply)
MD DDS DMD DO MS MPH PhD PNP PA
NNP Other:_____

**DEPARTMENT REQUESTED:**_____

**STAFF CATEGORY**:_____

## PERSONAL DATA

Last

Name_____First_____Middle_____

Other Name(s)

Used_____

Social Security Number_____Gender:

Male_____Female_____

Date of Birth_____Place of

Birth_____

Are you a US Citizen? ❑ Yes ❑ No If no, country of

citizenship_____

Visa Type_____ Visa

Number_____

If Foreign Medical School Graduate, ECFMG Certificate

Number_____

Foreign Languages

Spoken_____

NPI Number_____UPIN

Number_____

**Home**

**Address**_____

City_____State_____Zipcode_____

_

Home Phone_____Home Fax (if

applicable)_____

Preferred e-mail

Address_____

**Primary Office**

**Address**_____

City_____State_____Zipcode_____

_

Office Phone_____ Office

Fax_____

**Secondary Office**

**Address**_____

City_____State_____Zipcode_____

_

Office Phone_____ Office

Fax_____

# EDUCATION

**Undergraduate Education:**

College or University
Name_____
Address_____
_
City_____State_____Zipcode_____
_
Dates Attended_____Degree
Earned_____

College or University
Name_____
Address_____
_
City_____State_____Zipcode_____
_
Dates Attended_____Degree
Earned_____

**Medical School/Professional Education**

Medical/Professional
School_____
Address_____
_
City_____State_____Zipcode_____
_
Start Date_____Graduation Date_____Degree
Earned_____

Medical/Professional
School_____
Address_____
_
City_____State_____Zipcode_____
_

Start Date_____Graduation Date_____Degree Earned_____

**Master or Other Degree Program**

College or University Name_____

Address_____

City_____State_____Zipcode_____

Program or Course of Study_____

Dates Attended_____Degree Earned_____

College or University Name_____

Address_____

City_____State_____Zipcode_____

Program or Course of Study_____

Dates Attended_____Degree Earned_____

# POST GRADUATE TRAINING

**Internship**

Institution_____

_

Address_____

_

City_____State_____Zipcode_____

_

Phone Number_____Program Director_____

Type of

Internship_____Specialty_____

Dates Attended (Please provide

month/year)_____

Did you successfully complete this program ❑ Yes ❑ No (If "no" please explain on a separate sheet)

**Residencies**

Institution_____

_

Address_____

_

City_____State_____Zipcode_____

_

Phone Number_____Program Director_____

Type of

Residency_____Specialty_____

Dates Attended (Please provide

month/year)_____

Did you successfully complete this program ❑ Yes ❑ No (If "no" please explain on a separate sheet)

Institution_____

_

Address_____

_

City_____State_____Zipcode_____

_

Phone Number_____Program Director_____

Type of

Residency_____Specialty_____

Dates Attended (Please provide

month/year)_____

Did you successfully complete this program ❑ Yes ❑ No (If “no” please explain on a separate sheet)

**Fellowships**

Institution_____

_

Address_____

_

City_____State_____Zipcode_____

_

Phone Number_____Program Director_____

Type of Fellowship

_____Specialty_____

Dates Attended (Please provide

month/year)_____

Did you successfully complete this program ❑ Yes ❑ No (If “no” please explain on a separate sheet)

**Fellowships**

Institution_____

_

Address_____

_

City_____State_____Zipcode_____

_

Phone Number_____Program Director_____

Type of

Fellowship_____Specialty_____

Dates Attended (Please provide

month/year)_____

Did you successfully complete this program ❑ Yes ❑ No (If “no” please explain on a separate sheet)

Institution_____

_

Address_____

_

City_____State_____Zipcode_____

_

Phone Number_____Program Director_____

Type of

Fellowship_____Specialty_____

Dates Attended (Please provide

month/year)_____

Did you successfully complete this program ❑ Yes ❑ No (If “no” please explain on a separate sheet)

Institution_____

_

Address_____

_

City_____State_____Zipcode_____

_

Phone Number_____Program Director_____

Type of

Fellowship_____Specialty_____

Dates Attended (Please provide

month/year)_____

Did you successfully complete this program ❑ Yes ❑ No (If “no” please explain on a separate sheet)

## Board Certification and Specialty

Are you board certified? ❑ Yes ❑ No

Name of

Board_____

Dates Certified

from_____to_____

Recertification Dates from_____

to_____

Subspecialty Certification _____Date

Certified_____

Subspecialty Certification_____ Date

Certified_____

If you are not certified, indicate dates for testing_____

## Other Certification

**Indicate other certifications (to be completed by nurse practitioners, physician assistants, dentists, psychologists)**

Type of Certification_____ Certifying

Agency_____

Dates Certified

From_____To_____

Recertification

From_____To_____

Type of Certification_____ Certifying

Agency_____

Dates Certified

From_____To_____

Recertification

From_____To_____

## Licensure

**District of Columbia**

License Number_____ Expiration

Date_____

Controlled Substance Certificate _____ Expiration

Date_____

**Maryland**

License Number_____ Expiration

Date_____

Controlled Substance Certificate _____ Expiration

Date_____

**Virginia**

License Number_____ Expiration

Date_____

**Other States**

State_____Number_____Expiration

Date_____

State_____Number_____Expiration

Date_____

State_____Number_____Expiration Date_____

State_____Number_____Expiration Date_____

**Federal DEA**

Number_____ Expiration Date_____

Number_____ Expiration Date_____

Number_____ Expiration Date_____

## FACULTY / TEACHING APPOINTMENTS

Institution

Name_____

Address_____

_

City_____State_____Zipcode_____

_

Faculty Rank or other

Position___ _____

Dates of Appointment from_____ to

_____

Institution Name_____

_____

Address_____

_

City_____State_____Zipcode_____

_

Faculty Rank or other

Position___ _____

Dates of Appointment from_____ to

_____

## HOSPITAL STAFF AFFILIATIONS

**Please provide information on all hospital affiliations over the past ten (10) years. Attach additional pages, if necessary.**

Facility

Name_____

Address_____

_

City_____State_____Zipcode_____

_

Category or Status (active, courtesy,

etc)_____

Dates of Appointment from_____ to

_____

Facility

Name_____

Address_____
_
City_____State_____Zipcode_____
_
Category or Status (active, courtesy,
etc)_____
Dates of Appointment from_____ to
_____

Facility
Name_____
Address_____
_
City_____State_____Zipcode_____
_
Category or Status (active, courtesy,
etc)_____
Dates of Appointment from_____ to
_____

Facility
Name_____
Address_____
_
City_____State_____Zipcode_____
_
Category or Status (active, courtesy,
etc)_____
Dates of Appointment from_____ to
_____

**Hospital Affiliations (Continued)**

Facility
Name_____
Address_____
_
City_____State_____Zipcode_____
_
Category or Status (active, courtesy,
etc)_____

Dates of Appointment from_____ to

_____

Facility

Name_____

Address_____

_

City_____State_____Zipcode_____

_

Category or Status (active, courtesy,

etc)_____

Dates of Appointment from_____ to

_____

## Employment History

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary. Please explain any gaps on a separate page.

Practice/Institution/Employer

Name_____

Address_____Phone

_____

City_____State_____Zipcode_____

_

Dates of Employment from_____ to _____

Practice/Institution/Employer

Name_____

Address_____Phone

_____

City_____State_____Zipcode_____

_

Dates of Employment from_____ to _____

Practice/Institution/Employer

Name_____

Address_____Phone

_____

City_____State_____Zipcode_____

_

Dates of Employment from_____ to _____

Practice/Institution/Employer

Name_____

Address_____Phone

_____

City_____State_____Zipcode_____

_

Dates of Employment from_____ to _____

Practice/Institution/Employer

Name_____

Address_____Phone

_____

City_____State_____Zipcode_____

_

Dates of Employment from_____ to _____

## PROFESSIONAL LIABILITY INSURANCE

**Current Coverage**

*(Current coverage must provide a minimum of $1,000,000 per occurrence/$3,000,000 aggregate)*

Current Insurance

Carrier:_____

Address_____Phone

_____

City_____State_____Zipcode_____

_

Policy Number_____ Amounts $

_____ Coverage Dates from_____ to

_____

**Previous Coverage**

Previous Coverage (List all previous insurance carriers, beginning with the most current)

Previous Insurance

Carrier:_____

Address_____Phone

_____

City_____State_____Zipcode_____

_

Policy Number_____ Amounts $

_____ Coverage Dates from_____ to

_____

Previous Coverage (List all previous insurance carriers, beginning with the most current)

Previous Insurance

Carrier:_____

Address_____Phone

_____

City_____State_____Zipcode_____

_

Policy Number_____ Amounts $

_____ Coverage Dates from_____ to

_____

Previous Coverage (List all previous insurance carriers, beginning with the most current)

Previous Insurance

Carrier:_____

Address_____Phone

_____

City_____State_____Zipcode_____

_

Policy Number_____ Amounts $

_____ Coverage Dates from_____ to

_____

Previous Coverage (List all previous insurance carriers, beginning with the most current)

Previous Insurance

Carrier:_____

Address_____Phone

_____

City_____State_____Zipcode_____

_

Policy Number_____ Amounts $

_____ Coverage Dates from_____ to

_____

# Questionnaire

***Please read carefully and answer all questions.***

## HEALTH STATUS

**Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in the Bylaws of the Medical Staff as adopted from time to time by the Board of Directors. Among these qualification are the condition of the applicant's physical health and mental and emotional stability.**

| YES | NO | | |
|---|---|---|---|
| | | a. | Are you currently suffering from any physical or mental condition, including dependence on illegal drugs or alcohol, which would impair your ability to perform the requested privileges? |
| | | b. | Are you currently engaged in the illegal use or abuse of controlled substances or the misuse of alcohol? |

**If you respond in the affirmative to either of the above questions, please provide the following information on a separate sheet: Information regarding your recovery, including on-going therapy, support groups, mandatory or voluntary surveillance programs, as well as the name(s)/address(es) of the individual(s) involved in your medical and support care.**

| Yes | NO | | |
|---|---|---|---|
| | | a. | Are you able to perform all the procedures for which you have requested privileges, with or without accommodation, according to accepted standards of professional performance without posing a threat to patients? |

## DISCIPLINARY ACTIONS

**VOLUNTARILY OR INVOLUNTARILY: Have any of the following ever been, or are currently in the process of being denied, revoked, suspended, relinquished, withdrawn, reduced, limited, placed on probation, nor renewed, or currently pending/under investigation? If yes, please provide a complete explanation on a separate sheet.**

| Yes | No | | |
|---|---|---|---|
| | | a. | Medical license or registration in any state, district or foreign licensing board? |
| | | b. | Other professional license/registration? |
| | | c. | Drug Enforcement Agency (DEA) or other controlled substances certificate of registration? |
| | | d. | Academic appointment? |
| | | e. | Membership on any hospital staff? |
| | | f. | Clinical privileges, prerogatives/rights on any medical staff? |
| | | g. | Board certification? |
| | | h. | Any other type of professional sanction (e.g. peer review organization) and/or medical society? |
| | | i. | Have you resigned in order to avoid possible revocation, suspension, or reduction of privileges at any hospital or institution? |

## ADDITIONAL INFORMATION

**If you answer yes to any question, please provide a complete explanation on a separate sheet.**

| Yes | No | | |
|---|---|---|---|
| | | a. | Have you ever been arrested for or convicted of a felony, fraud or narcotics offense? |
| | | b. | Under federal or state law, have you ever been arrested for, or convicted of, a crime involving children? |
| | | c. | Have you ever been suspended, sanctioned,, or otherwise restricted from participating in private, |

| Yes | No | | |
|---|---|---|---|
| | | | federal or state health insurance programs (for example Medicare, Medicaid, or any other third party payment programs)? |
| | | d. | Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program? |
| | | e. | Are you an owner, officer or principal in any company, corporation, and/or diagnostic facility that bills the Medicare program? If yes, please identify: |

## MEDICAL MALPRACTICE INFORMATION

**If you answer yes to any question, please provide a complete explanation on a separate sheet.**

| Yes | No | | |
|---|---|---|---|
| | | a. | Has your present or any previous professional liability insurance carrier excluded any categories of professional practice from your coverage, or raised your rates because of your own professional liability experience? |
| | | b. | Have you been the subject of any medical malpractice action in the past TEN years? This includes lawsuits that may have later been dropped, dismissed or settled without the necessity of a trial? |
| | | c. | Have you ever had a lawsuit filed against you alleging fraud? |
| | | d. | Have you ever had a settlement paid on your behalf as a result of a lawsuit or a claim alleging fraud, professional liability or medical malpractice? |
| | | e. | Have you had a professional liability or medical malpractice claim brought against you which was settled or resolved prior to the initiation of a lawsuit and which involved the payment of funds in excess of $5,000? |
| | | f. | Has your professional liability insurance ever been denied, cancelled, or have any professional liability insurance carrier refused to renew your policy? |

## PEDIATRIC EXPERIENCE

If you are not certified by the American Board of Pediatrics, please list your pediatric experience and/or special expertise in pediatric areas below including an indication of volume or percent of practice. (Please attach a separate sheet if more space is needed)

# AUTHORIZATION STATEMENT

I hereby affirm and attest that all answers, statements, and information contained in this application are correct and complete to the best of my knowledge and belief. I understand that falsification, misrepresentation, or omission of any fact(s) requested will be sufficient cause for denial of this application and/or subsequent termination of any participating privileges granted upon the basis of this application. I understand that the information contained in this application will be used to evaluate my credentials according to the quality assessment standards of each managed care plan.

_____ _____

Signature Date

**APPLICANT'S CONSENT AND RELEASE**

I hereby apply for medical staff appointment and clinical privileges as requested above. I am willing to make myself available for interviews in regard to this application.

As an applicant, I have the burden of providing adequate information for proper evaluation of my application. I also agree to provide the Hospital with updated current information regarding all questions on this application form as such information becomes available and such additional information as may be requested by the Hospital or its authorized representatives. Failure to produce this information or additional information within six months from the date of application will prevent my application from being evaluated and acted upon.

I certify that information given in or attached to this application is accurate and fairly represents the current level of my training, experience, capability and competence to practice with the clinical privileges requested. As a condition to making 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 resulting in denial of appointment and clinical privileges. In the event that appointment or privileges have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of such appointment or privileges.

By applying for appointment and clinical privileges, I accept the following conditions during the processing and consideration of my application, regardless of whether or not I am granted appointment or privileges, and for the duration of such appointment or reappointments 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 (C) below, for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, performed, made, requested or received by this Hospital and its authorized representatives to, from 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 undertaken for reappointment or for increase or decrease in clinical privileges;
(3) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary sanction;
(4) summary suspensions;
(5) hearings and appellate reviews;
(6) medical care evaluations;
(7) utilization reviews;
(8) any other Hospital, Medical Staff, department, service or committee activities;
(9) reviewing, reporting or responding to inquiries concerning my professional qualification, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and
(10) any other matter that might directly or indirectly have an effect on my competence, on patient care or on the orderly operation of this or any other Hospital or health care facility.

The foregoing shall be privileged to the fullest extent permitted by laws. Such privilege shall extend to the Hospital and its authorized representatives, and to any third parties.

(B) I specifically authorize the 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 appointment to the medical staff, as well as to inspect or obtain any and all communications, reports, records, statement, documents, 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) The term "Hospital and its authorized representatives" means the Hospital corporation and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct in the hospital: the members of the Hospital Board and their appointed representatives, the Chief Executive Officer or his designees, other Hospital employees, consultants to the Hospital, the Hospital's attorney and his partners, associates or designees, and all members of the Medical Staff. The term "third parties" means al individuals, including members of the Hospital's Medical Staff, and members of the Medical Staff of other Hospitals or other physicians or health care practitioners, nurses or other government agencies, including the National Practitioner Data Bank, organizations, associations, partnerships and corporations, whether or not Hospitals or health care facilities, from whom information has been requested by the Hospital or its authorized representatives or who have requested such information from the Hospital and its authorized representatives.

I acknowledge that (1) medical staff appointment and clinical privileges at this Hospital are not a right of every licensed professional who makes application for the same; (2) my request will be evaluated in accordance with prescribed procedures

defined in the Hospital and Medical Staff Bylaws, Rules and Regulations, and Board Policy on Medical Staff Appointment and Clinical Privileges; (3) all medical staff recommendations relative to my application are subject to the ultimate action of the Hospital Board, whose decision shall be final; (4) if appointed, my initial appointment and clinical privileges shall be provisional for the time period determined by the Board; (5) I have the responsibility to keep this application current by informing the Hospital, through the Chief Executive Officer, of any change in my professional liability insurance coverage, the filing of a lawsuit against me and any change in the status of my clinical privileges at any other Hospital; and (6) reappointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the Hospital, as evidenced by admission, treatment and continuous care and supervision of patients for whom I have responsibility and acceptable performance of all responsibilities related thereto as well as the other factors deemed relevant by the Hospital. Reappointment and continued clinical privileges shall be granted only on formal application, according to Hospital and Medical Staff Bylaws, Rules and Regulations and policies, and upon final approval of the Hospital Board.

I have received and had an opportunity to read a copy of the Bylaws of the Hospital and such Hospital policies and directives as are applicable to members of the Medical Staff, including the Bylaws and Rules and Regulations of the Medical Staff presently in force. I specifically agree to abide by all such Bylaws, policies, directives and Rules and Regulations as are in force during the time I am appointed or reappointed to the Medical Staff or exercise clinical privileges at the Hospital.

If appointed or granted clinical privileges, I specifically agree that I: (1) will not split fees or accept financial inducements for patient referrals; (2) will not delegate responsibility for diagnoses or care of hospitalized patients to any other individual who is not qualified to undertake this responsibility or who is not adequately supervised; (3) will not deceive patients as to the identify of any operating surgeon or any other individual providing treatment or services; (4) will seek consultation whenever necessary or required; (5) will abide by generally recognized ethical principles applicable to my profession; (6) will provide continuous care and supervision as needed to all patients in the Hospital for whom I have responsibility; and (7) will accept committee assignments and such other duties and responsibilities as shall be assigned to me by the Hospital Board, department chairman and Medical Staff.

In an emergency, I understand that I shall be authorized to treat any disorders and diseases and/or perform any medical and surgical procedures as may be necessary in my judgment.

DATE:_____SIGNATURE:_____

Revised: 4/15/11

**Explanation and Understanding of Children's Hospital**
**Medical Staff Appointment Procedures**
**for newly hired employed members of the Medical Staff**

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Credentialing Procedure Explanation

As part of the appointment process to the Medical Staff of Children's Hospital, the Medical Staff Office verifies information contained in all applications. This is a time consuming process that includes written verification of medical education, residency training, licenses held, malpractice experience with previous insurance carriers, health attestation statement, references and verification of good standing at institutions where privileges have been held. Any gaps in this information have to be explained in writing. The Medical Staff requires the applicant to have a DC license to practice their discipline; a state-level, DC narcotics license and a federal narcotics license (DEA) with a DC address. Membership may also be given based on licensing in Maryland or Virginia. For individuals transferring from another jurisdiction, the Medical Staff will allow the application to proceed for consideration so long at the applicant agrees to transfer their DEA to DC within 30 days of arrival. Any issues that arise during the verification process such as malpractice claims require that the application be considered at a credentials committee meeting.

The Medical Staff Office notifies individuals once they have cleared the credentials committee step are eligible for and have been granted temporary privileges.

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Agreement

Children's Hospital may be extending employment to me in anticipation of an appointment to the Medical Staff of Children's Hospital. I have also executed or will be executing an application for Appointment to the Medical Staff of Children's Hospital. However malpractice insurance coverage, managed care panel participation and privileges at Children's Hospital are conferred upon appointment to the Medical Staff or upon granting of any temporary privileges by the Chief Executive Officer of Children's Hospital.

Therefore I understand that until such time as that appointment is conferred upon me by the Board of Directors of Children's Hospital, or until such time as I am granted temporary privileges by the Chief Executive Officer of Children's Hospital, I agree that I shall not participate in direct patient care activities at Children's Hospital. "Direct patient care activities" is defined as examining, documenting, diagnosing or treating any patient of Children's Hospital. I may participate in rounds but may not make entries into the patient's medical record. An exception may be made for emergency temporary privileges as defined in the Bylaws of the Medical Staff of Children's Hospital.

I have read and understand this agreement.

_____ _____

Applicant Date

## PEER REFERENCES

**Please provide information below for three peer references. At least one of these peer references must be your training program director if you have recently completed your training program, or your immediate supervisor, department chair, division chief, etc. if you have been in practice.**

Name:_____

Address:_____

City, State, Zipcode:_____

Phone:_____ Fax:_____

E-mail Address:_____

Title or Position:_____

**********

Name:_____

Address:_____

City, State, Zipcode:_____

Phone:_____ Fax:_____

E-mail Address:_____

Title or Position:_____

**********

Name:_____

Address:_____

City, State, Zipcode:_____

Phone:_____ Fax:_____

E-mail Address:_____

Title or Position:_____

**STATEMENT OF**
**PHYSICAL AND MENTAL COMPETENCY**

*The District of Columbia Department of Health and the Children's Hospital Medical Staff Bylaws require each member of the medical staff to submit an annual Statement of Physical and Mental Competency to be certified by another licensed independent practitioner. Failure to provide this information bi annually may lead to suspension and relinquishment of your medical staff privileges.*

Name: _____

**Section I: Tuberculin Status**

Each practitioner is required to have an bi-annual PPD skin test unless the practitioner has a history of previous positive skin test reaction.

PPD administered by _____ Date _____
(*Self-administering is not allowed*) (*Must be within the last 12 months*)

PPD read by _____ Date _____
(*Self-reading is not allowed*) (*Must be read within the last 72 hours*)

Interpretation ❑ Negative ❑ Positive

❑ **Check if this practitioner has a history of previous positive skin test reaction.**

Most recent chest x-ray performed on: _____

Interpretation ❑ Negative ❑ Positive

Does the practitioner currently have any of the following signs or symptoms?

| | | |
|---|---|---|
| 1. Unexplained fever for more than one week | ❑ No | ❑ Yes |
| 2. Sweats at night | ❑ No | ❑ Yes |
| 3. Chronic cough with mucus | ❑ No | ❑ Yes |
| 4. Unexplained weight loss | ❑ No | ❑ Yes |
| 5. Unexplained chest pain with breathing | ❑ No | ❑ Yes |

**Section II: Certification of Competency**

I certify that the above-named practitioner has been examined by me and found to be physically and mentally competent to perform duties associated with membership and privileges on the Medical Staff of Children's Hospital.

Date of the Physical Exam: _____ (Should *be within last 6 months*)

Signature: _____ Date: _____

Print Name: _____

Address: _____

_____

Telephone: _____

**Please return this form to:**
Children's Hospital
Medical Staff Office
12211 Plum Orchard Drive, Suite 310, Silver Spring, MD 20904
Phone (301) 572-1327 · Fax (301) 572--1312