OSUCOM / MCSO

Oklahoma State University College of Osteopathic Medicine
Medical Center of Southeastern Oklahoma
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Medical Center of Southeastern Oklahoma
Application for Family Medicine Residency Program
Appointment and Clinical Privileges

INSTRUCTIONS:

1. Please print all information clearly. If the existing space is insufficient, attach additional sheets and reference the question being answered.
2. **Enclose a recent photograph and Curriculum Vitae**.
3. Incomplete applications will be returned.

PERSONAL DATA

Last Name	First Name	Middle Name	Maiden Name

List all names under which you were enrolled, licensed , or also known as:

Social Security Number: AOA Number:	Birth Date	Birthplace	Date of Application

Permanent Resident Address	Telephone	City	State	Zip Code
Answering Service #	Fax Number	Beeper #	Car Phone Number	

Marital Status: ____Single ____Married ___Divorced ___Separated ___Widowed If Married Spouse's Name__________________

Citizenship	If not U.S. Citizen Status of your Visa	Expiration Date	UPIN #

Names and Ages of Children

STAFF CATEGORY

Please indicate the staff category to which you wish to be appointed, as well as specific clinical privileges you would like to exercise.

1. Staff Category: _Family Practice Residency Program
2. Clinical Service: _Family Practice________________

ACLS Certified?	Expiration	CPR Certified?	Expiration

PROFESSIONAL DATA

AFFILIATIONS

List all present and previous affiliations and Medical Staff memberships in chronological order, beginning with the most recent dates (include assistantships and appointments). All time periods must be accounted for.

DATE	FACILITY NAME	ADDRESS	DEPARTMENT AND STATUS

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 care facility (e.g., hospital, HMO, PPO)?		
2. Has your application for appointment to the medical staff of any other health care facility ever been denied?		
3. Have you voluntarily or involuntarily resigned from the medical staff of any health care facility?		

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

MILITARY SERVICE

Branch of Service:	Dates:
Title:	Highest Rank:
Type of Discharge:	Reserve Status:

LICENSE(S) for PRACTICE: **PLEASE LIST ALL LICENSES**

STATE	LICENSE NUMBER	PROFESSION	EXPIRATION DATE

DEA #	EXP. DATE	OBNDD Number	EXPIRATION. DATE	Medicare Number	Medicaid Number

Does your DEA/State Controlled Substance Number reflect schedules 2, 2N, 3, 3N, 4 and 5?	Yes	No

If the answer is NO, please explain:____.

NOTE: A copy of licenses and Certificate of Insurance must be included with this Application. The current original DEA registration Number and State Controlled Substance Number (if applicable) must be brought to the Medical Staff Office for verification.

Please answer the following questions in full detail.

If the answer to any of the questions is **YES**, and you need more space please attach a separate sheet with detailed information.

	YES	NO
Have any disciplinary actions ever been initiated and/or are any now pending against you by any state licensure board:		
Has your license to practice medicine in any state ever been denied, limited, suspended, or revoked, placed on probation, or voluntarily/involuntarily relinquished or challenged?		
Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal of state health insurance program (for example, Medicare or Medicaid)?		
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?		
Has your DEA/State Controlled Substance Number ever been limited, suspended, revoked, or voluntarily/involuntarily relinquished?		
Have you ever been a defendant in a criminal proceeding?		
List participation in any private health insurance program:		
Have you ever been convicted of a felony?		
Have you ever been convicted of a misdemeanor (other than traffic citations)?		
Have you ever been treated for substance abuse or addiction?		
Have you ever been subjected to disciplinary action by any school or hospital		

EDUCATION

TYPE	NAME	MAILING ADDRESS (INCLUDING ZIP CODE)	DEGREE	DATES ATTENDED	
Medical School				From	To
Undergraduate College or University				From	To
Other:				From	To

If medical or other professional school was not in the United States, Canada, or Puerto Rico, please attach a copy of ECFMG Certificate. ECFMG Number:________________ Date of Certificate:______________________

INTERNSHIPS

Institution Name	Mailing Address	City	State	Zip Code
Type of Internship	Dates Attended From: To:	Program Director		

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

RESIDENCIES

Institution Name	Mailing Address	City	State	Zip Code
Type of Residency	Dates Attended From: To:	Department Chairman		
Institution Name	Mailing Address	City	State	Zip Code
Type of Residency	Dates Attended From: To:	Department Chairman		

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

FELLOWSHIPS

Institution Name	Mailing Address	City	State	Zip Code
Type of Fellowship	Dates Attended From: To:	Department Chairman		

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

TEACHING APPOINTMENTS

Institution Name	Mailing Address	City	State	Zip Code
Type of Appointment	Effective Date From: To:	Department Chairman		

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

During your internship, residency, fellowship or teaching appointment (as applicable):
If YES, please attach a sheet with detailed information.

	Yes	No
a) Were you ever disciplined, suspended, placed upon probation, formally reprimanded, or asked to resign?		
b) Have you had to leave for 30 or more consecutive days?		

PROFESSIONAL SOCIETIES

NAME OF SOCIETY	DATE OF MEMBERSHIP	
Have you ever been denied membership or renewal thereof, or been subjected to disciplinary proceedings in any professional organization? If YES please attach a sheet with details.	Yes	No

INSURANCE

Present Insurance Carrier	Address	City	State	Zip Code

Policy Number	Type of Policy __Occurrence __Claims made	Retroactive Date	Effective Date	Expiration Date	Claim Limit	Aggregate Limit

	YES	NO
1. Has your professional liability insurance coverage ever been terminated by action of an insurance company?		
2. Have you ever been denied professional liability insurance coverage or rated in a higher than average risk class for your professional specialty?		

If the answer to question 1 or 2 is YES, state when and by what company

List all insurance carriers for the last five (5) years:

INSURANCE CARRIER	FROM	TO	TYPE OF POLICY	CLAIM LIMIT	POLICY NUMBER
			__OCCURRENCE __CLAIMS MADE		
			__OCCURRENCE __CLAIMS MADE		
			__OCCURRENCE __CLAIMS MADE		
			__OCCURRENCE __CLAIMS MADE		

LEGAL ACTIONS

	YES	NO
1. Have any professional liability claims or suits ever been filed against you?		
2. Have any professional liability claims or suits ever been filed against you that are presently pending?		
3. Have any judgements been made against you in a professional liability case(s) or claim(s) or have you Entered into any settlements?		

If the answer to any of the above questions is YES, please complete the attached malpractice claims/suits history form.

HEALTH STATUS

Every applicant must furnish complete information concerning the following:

a) Health impairments, if any, affecting the applicant's ability in terms of skill, attitude, or judgement to perform professional and medical duties connected with their graduate medical education program;
b) Hospitalizations or other institutionalization for significant health problems during the past five year period;
c) Any continuing health problems requiring current therapy;
d) Denials of, or ratings on health, life, or disability insurance because of health problems, and names of insurers;
e) Statement from personal physician of significant findings on last health examination
f) f)Are you able to perform the functions relevant to the privileges you have requested? _____YES_____NO

If the answer is NO, please provide additional information.

____
Applicant's Signature

If you do have a physical or mental condition known to you, please attach documentation explaining your condition.

If you have no physical or mental health condition known to you, please sign the following statement:

"To the best of my knowledge, I suffer from no physical or mental health impairments that would affect my graduate medical education program at the Durant Family Medicine Residency Program."

_______________________________ _______________________________________

Applicant printed Name   Applicant's Signature   Date

REFERENCES

List three professional references who have personal knowledge and can evaluate your performance, not including Department Chairman, Chief of Staff, current partners, associates in practice or relatives. Provide current complete addresses include zip codes.

NAME	MAILING ADDRESS	TELEPHONE

Professional Articles
Published:____

What are your plans after completion of your post graduate training?

Other information pertinent to your selection as a resident in Durant?

APPLICANT'S CONSENT AND RELEASE

I hereby apply for medical staff appointment and clinical privileges as requested in this application and, I acknowledge, consent, and agree as follows:

As an applicant for appointment, I have the burden for producing adequate information for proper evaluation of my qualifications. I also agree to update the hospital/health plan with current information regarding all questions contained in this application as such information becomes available and any additional information as may be requested by the hospital/health plan or its authorized representatives. Failure to produce any such information will prevent my application for appointment from being evaluated and acted upon.

Information given in or attached to this application is accurate and complete to the best of my knowledge. I fully understand and agree that as a condition to making this application, any misrepresentations or misstatements in, or omission from it, 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 misrepresentations, misstatement or omission, such discovery may result in immediate termination of such appointment or privileges.

I accept the following conditions:

A) I extend immunity to, and release from any and all liability, the hospital/health plan, its authorized representatives and any third parties, as defined in Subsection C below, for any acts, communications, recommendations or disclosures involving me; performed, made, requested or received by this hospital/health plan 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; 3) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action; 4) summary suspensions; 5)hearings and appellate reviews; 6) medical care evaluations; 7)utilization reviews; 8) any other hospital/health plan, medical staff, department, service or committee activities; 9) matters or inquiries concerning my professional qualifications, credentials, clinical competence, character, mental 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 hospital/health plan or health care facility.

B) I specifically authorize the hospital/health plan 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 hospital/health plan and its authorized representatives upon request.

C) The term "hospital/health plan and its authorized representatives" means the hospital/health plan corporation and any of the following individuals who have the responsibility for obtaining or evaluating my credentials, or acting upon my application of conduct in the hospital/health plan: the members of the hospital's/health plan's Board and their appointed representatives, the Chief Executive Officer or his designees, other hospital/health plan employees, consultants to the hospital/health plan, the hospital/health plan's attorney and his/her partners, associates or designees, and all appointees to the medical staff. The Term "third parties" means all individuals, including appointees to the hospital's/health plan's medical staff, and appointees to the medical staffs of other hospitals/health plans or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether hospitals/health plans, health care facilities or not, from whom information has been requested by the hospital/health plan or its authorized representatives or who have requested such information from the hospital/health plan and its authorized representatives.

I acknowledge that (1) medical staff appointment and clinical privileges at this hospital/health plan are not a right; (2) my request will be evaluated in accordance with prescribed procedures defined in the hospital/health plan and medical staff bylaws, rules and regulations; (3) all medical staff recommendations relative to my application are subject to the ultimate action of the hospital/health plan Board whose decision shall be final; (4) if appointed, my appointment and clinical privileges shall be provisional; (5) I have the responsibility to keep this application current by informing the hospital/health plan, through the Chief Executive Officer, of any change in the areas of inquiry contained herein; and (6) appointment and continued clinical privileges remain contingent upon my continued 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 other factors that are relevant to the effective and efficient operation of the hospital/health plan. Appointment and continued clinical privileges shall be granted only on formal application, according to hospital/health plan and medical staff bylaws, rules and regulations, and upon final approval of the hospital/health plan Board.

I have received and had an opportunity to read a copy of the medical staff bylaws and such hospital/health plan policies and directives as are applicable to appointees to 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, and as they may hereafter be amended, during the time I am appointed or re-appointed to the medical staff or exercise clinical privileges at the hospital/health plan.

If appointed or granted clinical privileges, I specifically agree to: (1) refrain from fee-splitting or other inducements relating to patient referral; (2) 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; (3) refrain from deceiving patients as to the identity of any practitioner providing treatment or services; (4) seek consultation whenever necessary or required; (5)abide by generally recognized ethical principles applicable to my profession; (6) provide continuous care and supervision as needed to all patients in the hospital/health plan for whom I have responsibility; and (7) accept committee assignment and such other duties and responsibilities as shall be assigned to me by the hospital/health plan Board and medical Staff.

All information submitted by me in this application is true and complete to the best of my knowledge. A Photostatic copy of this original statement constitutes my written authorization and request to release any and all documentation relevant to this application.

I will appear and answer any questions pertaining to my application.

APPLICANT'S PRINTED NAME APPLICANT'S SIGNATURE DATE

RECOMMENDATION AND APPROVAL SHEET – RESIDENCY APPOINTMENT

Applicants Name:______________________________________ **Staff Category:** RESIDENCY PROGRAM___

Medical Executive Committee Recommendations

I have received and carefully reviewed Appointment data and information regarding the following:

EDUCATION AND TRAINING			
Medical School	Yes	No	Comments:
Internship(s)	Yes	No	Comments:
Residency(s)	Yes	No	Comments:
Fellowship(s) Teaching Appointment(s)	Yes	No	Comments:
ECFMG Verification	Yes	No	Comments:
RELEVANT EXPERIENCE AND CURRENT COMPETENCE			
Affiliation Responses	Yes	No	Comments:
Peer Recommendations	Yes	No	Comments:
ABILITY TO CARRY OUT PRIVILEGES REQUESTED STATUS			
Any physical or mental limitations, which would prevent the applicant from carrying out privileges as requested.	Yes	No	Comments:
LICENSURE AND CERTIFICATION			
Licensure issues (past and present in all jurisdictions)	Yes	No	Comments
DEA & State Substance License issues (past and present)	Yes	No	Comments:
Board Certification issues (past and present)	Yes	No	Comments:
LIABILITY			
Insurance Verification	Yes	No	Comments:
Coverage	Yes	No	Comments:
Suits/claims filed/pending, judgements/final settlements	Yes	No	Comments:
OTHER			
NPDB Query Results	Yes	No	Comments:

MEDICAL STAFF EXECUTIVE COMMITTEE RECOMMENDATIONS

Based on the committee evaluation of the education, training, and current competence, ability, skill, judgement data and information (as indicated in the YES column of this sheet) We recommend the following:

____Applicant is granted the specific privileges requested. ____Applicant be granted medical staff member ship as requested.

____Applicant not be granted specific privileges requested. ____Applicant not be granted medical staff membership as requested.

Applicant be granted privileges requested with the following modifications:
Comments:

______________________________________ ______________________________

Medical Staff Executive Committee Chairman Date

GOVERNING BODY APPROVALS

Based on the committee evaluation of the education, training, and current competence, ability, skill, judgement data and information (as indicated in the YES column of this sheet) We recommend the following:

____Applicant is granted the specific privileges requested. ____Applicant be granted medical staff member ship as requested.

____Applicant not be granted specific privileges requested. ____Applicant not be granted medical staff membership as requested.

Applicant be granted privileges requested with the following modifications:

Comments:

______________________________________ ______________________________

Chairman of the Board Date

Basic Requirements for Osteopathic Family Medicine Residency Applicants

1. U.S. Citizen or a non-citizen/foreign national with a permanent resident visa.

2. Graduate of a recognized college of osteopathic medicine and surgery.

3. Completion of a one-year rotating internship.

4. Member of A.O.A. / A.C.F.P. and O.O.A.

5. Licensed or able to be licensed to practice within thirty days of beginning Residency in the State of Oklahoma.

7. A personal interview with the Committee on Graduate Medical Education and Training (COGMET) and affiliated institutional personnel.

INSTRUCTIONS TO APPLICANTS:

1. All required materials must be received by Committee on Osteopathic Graduate Medical Education and Training (COGMET) within a reasonable amount of time.

2. THE FOLLOWING MATERIALS CONSTITUTE A COMPLETED APPLICATION PACKET:

[ ] The completed application form (typed or printed - black ink only)

[ ] Medical School Transcript

[ ] Copy of all National Osteopathic Board Examination scores.

[ ] Four references (Letters/Forms to be mailed directly to the Program Director)
(a) Dean of Osteopathic College [ ]
(b) Internship Director of Medical Education [ ]
(c) Two practicing Osteopathic physicians [ ]

[ ] Authorization for Release of Information / Release from Civil Liability Form

[ ] Health Status Form

[ ] Recent Photograph

[ ] A written statement detailing your reasons for seeking a Residency at Durant Osteopathic Family Medicine Residency Program. Please include information about your motivation toward Osteopathic Family Medicine and any long-range career plans.

Selection Process:

1. Applications and correspondence shall be directed to the Program Director. The candidate will be interviewed by the Program Director, Chairman of COGMET, and other associated Family Practice physicians, as appropriate. Initial selection of the resident will be made by the Program Director in association with appropriate Family Practice Department Members and the Chairman of COGMET.

2. Recommendation for appointment shall be made by the COGMET to the Medical Staff of Medical Center of Southeastern Oklahoma via the Medical Staff Executive Committee.

3. Appointment of the resident shall be confirmed and be made by the Administrator of Medical Center of Southeastern Oklahoma.

4. Candidates for residency training shall be notified of appointment or failure of appointment by the Secretary of Residency Training.

5. The selected resident(s) shall be notified that appointment is on a one (1) year basis, subject to renewal annually for the term of the residency, based upon evaluation and progress. The resident shall be informed that his/her work will be evaluated periodically and shall included personal and written reviews with the Program Director quarterly for the purpose of determining mutual satisfaction and/or continuation in the program.