

Work History – <i>continued</i>			
Gap Dates:		Explanation:	
Gap Dates:		Explanation:	
<input type="checkbox"/> Please check this box and complete and submit Attachment C if you have additional work history			
Hospital Affiliations –Please include all hospitals where you currently have or have previously had privileges.			
DO YOU HAVE HOSPITAL PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YOU DO NOT HAVE ADMITTING PRIVILEGES, WHAT ADMITTING ARRANGEMENTS DO YOU HAVE?	
PRIMARY HOSPITAL WHERE YOU HAVE ADMITTING PRIVILEGES			START DATE (MM/YYYY)
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)		ARE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO PRIMARY HOSPITAL?			
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES			START DATE (MM/YYYY)
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)		ARE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?			
<input type="checkbox"/> Please check this box and complete and submit Attachment D if you have additional <u>current</u> hospital affiliations.			
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES			AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)		WERE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No
REASON FOR DISCONTINUANCE			
<input type="checkbox"/> Please check this box and complete and submit Attachment E if you have additional <u>previous</u> hospital affiliations.			
References –Please provide three peer references from the same field and/or specialty who are not partners in your own group practice and are not relatives. All peer references should have firsthand knowledge of your abilities.			
1 NAME/TITLE			PHONE NUMBER
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE