CMU CENTRAL MICHIGAN UNIVERSITY | College of Medicine

Dear Physician:

Please complete the enclosed application and return with copies of the following:

1) Medical school diploma
2) Intern/Resident certificates
3) Current MI medical license and controlled substance license
4) Current DEA registration certificate
5) Board certification or intentions if not board certified
6) Certificate of professional liability insurance
7) Documentation of TB testing within the last twelve months (for hospital privileging)
8) Documentation of numbers/types of hospital cases during the past 24 months (for hospital privileging)
9) CME documentation for the past 24 months (for hospital privileging)
10) National Provider Identifier (NPI)
11) Photograph
12) Copy of Driver's License

The application must be completed in its entirety and submitted to the Faculty and Staff Affairs Office in order to start the academic credentialing and appointment process. It is the responsibility of the applicant to ensure all of the required information is provided to our office for review. If you do not have all of your required documents at this time, attach what is available and forward the remainder under separate cover as soon as possible.

Pleas return the application and supporting documents to:

Attn: Credentialing
Faculty & Staff Affairs | CMED South
Central Michigan University
2520 S. University Par Dr., Bldg. D
Mt. Pleasant, MI 48859

Questions regarding the application process may be directed to me at (989) 774-2998, or by email at sarah.cresswell@cmich.edu. I look forward to helping you with the application process.

Sincerely,

Sarah Cresswell
Credentialing Coordinator

P 989-774-2998
F 989-774-7658
Central Michigan University
Mount Pleasant, Michigan 48859
med.cmich.edu

APPLICATION FOR FACULTY APPOINTMENT

CMU CENTRAL MICHIGAN UNIVERSITY | College of Medicine

This form should be typed or legibly printed in blank ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Return all completed applications to: Faculty & Staff Affairs | CMED South, 2520 S. University Park Drive, Bldg D., Mount Pleasant, MI 48859

If a particular field is not applicable to you, please indicate with "N/A".

SECTION 1 – DEMOGRAPHICS

APPLICANT INFORMATION							
Last Name		First		M.I.		Degree(s)	
Other names used							
Street Address				Apartment/Unit #			
City		State		ZIP			
Telephone Number		E-mail Address					
Proposed Start Date		Department		Program			
Birth Date		Birth Place					
Languages		Social Security No.					
Specialty		Sub Specialties					
Are you a citizen of the United States?	YES ☐	NO ☐	If no, are you authorized to work in the U.S.?	YES ☐	NO ☐		
OFFICE INFORMATION							
Name of Practice/Affiliation or Clinic Name:		Department Name					
Primary Office Street Address							
City		State		ZIP			
Office Manager		Telephone Number		Fax Number			

SECTION 2 – EDUCATION/CLINICAL TRAINING

UNDERGRADUATE EDUCATION							
College or University Name							
Address (street, city, state, zip code)							
Degree Received		Graduation Date (MM/YYYY)					
MEDICAL/PROFESSIONAL EDUCATION							
College or University Name		Degree Received					
Address (street, city, state, zip code)							
From (MM/YYYY)		To (MM/YYYY)		Did you graduate?	YES ☐	NO ☐	Graduation Date

OTHER POSTGRADUATE EDUCATION (Attach additional sheet if necessary)				☐ Does not apply	
Institution		Dates Attended			
Address (street, city, state, zip code)					

INTERNSHIP (Attach additional sheet if necessary)					☐ Does not apply
Institution		Phone Number			
Address (street, city, state, zip code)					
From (MM/YYYY)	To (MM/YYYY)		Did you complete?	YES ☐	NO ☐
Program Specialty		Program Director			

RESIDENCIES (Attach additional sheet if necessary)					☐ Does not apply
Institution		Phone Number			
Address (street, city, state, zip code)					
From (MM/YYYY)	To (MM/YYYY)		Did you complete? (if NO, please explain on separate sheet)	YES ☐	NO ☐
Program Specialty		Program Director			
Institution		Phone Number			
Address (street, city, state, zip code)					
From (MM/YYYY)	To (MM/YYYY)		Did you complete? (if NO, please explain on separate sheet)	YES ☐	NO ☐
Program Specialty		Program Director			

FELLOWSHIPS (Attach additional sheet if necessary)					☐ Does not apply
Institution		Phone Number			
Address (street, city, state, zip code)					
From (MM/YYYY)	To (MM/YYYY)		Did you complete? (if NO, please explain on separate sheet)	YES ☐	NO ☐
Program Specialty		Program Director			
Institution		Phone Number			
Address (street, city, state, zip code)					
From (MM/YYYY)	To (MM/YYYY)		Did you complete? (if NO, please explain on separate sheet)	YES ☐	NO ☐
Program Specialty		Program Director			

SECTION 3 - EMPLOYMENT

FACULTY/TEACHING APPOINTMENTS (Attach additional sheet if necessary)			☐ Does not apply
Current Institution		Dates Appointed	
Address (street, city, state, zip code)			

Training		Faculty Director	

WORK HISTORY/INSTITUTIONAL AFFILIATIONS (Attach additional sheet if necessary)

This section must be completed. A curriculum vitae is not acceptable in place of completing this section. Chronologically list all work history activities and institutional affiliations since completion of professional education (use extra sheets if necessary). Include all employment and affiliations with hospitals, other corporations, the military, or governmental agencies. Account for all periods of time between the date of medical/professional school graduation to the present, including dates, activity, and names where applicable.

Employer/Hospital/ Institution/Practice					Contact Person		
Department/Specialty				Staff Category (Hospital)			
From (MM/YYYY)		To (MM/YYYY)		Telephone Number		Fax Number	
Address (street, city, state, zip code)							
Reason For Leaving:							
Employer/Hospital/ Institution/Practice					Contact Person		
Department/Specialty				Staff Category (Hospital)			
From (MM/YYYY)		To (MM/YYYY)		Telephone Number		Fax Number	
Address (street, city, state, zip code)							
Reason For Leaving:							
Employer/Hospital/ Institution/Practice					Contact Person		
Department/Specialty				Staff Category (Hospital)			
From (MM/YYYY)		To (MM/YYYY)		Telephone Number		Fax Number	
Address (street, city, state, zip code)							
Reason For Leaving:							
Employer/Hospital/ Institution/Practice					Contact Person		
Department/Specialty				Staff Category (Hospital)			
From (MM/YYYY)		To (MM/YYYY)		Telephone Number		Fax Number	
Address (street, city, state, zip code)							
Reason For Leaving:							

TIME INTERVALS

Please account for all periods of time between date of medical/professional school graduation to present not covered elsewhere in this application. Include dates, activity and names where applicable (use extra sheets if necessary).

Suspended from Practice		From (MM/YYYY)		To (MM/YYYY)	

Loss of License		From (MM/YYYY)		To (MM/YYYY)	
Served in Military		From (MM/YYYY)		To (MM/YYYY)	
Personal Leave		From (MM/YYYY)		To (MM/YYYY)	
Other (Please describe)		From (MM/YYYY)		To (MM/YYYY)	

SECTION 4 – LICENSURE/REGISTRATIONS & CERTIFICATIONS

LICENSURE

Physicians at CMU College of Medicine are responsible for obtaining the appropriate licensures to practice medicine in the State of Medicine and are also responsible for maintaining active and current licensure for patient care. Licensed status must be maintained for the duration of your appointment.

Michigan State Medical/Professional License No.		Issue Date (MM//DD/YYYY)		Expiration Date (MM/DD/YYYY)	
Michigan State Controlled Substance No.				Expiration Date (MM/DD/YYYY)	
Drug Enforcement (DEA) Administration Certification No.				Expiration Date (MM/DD/YYYY)	

ALL OTHER STATE MEDICAL/PROFESSIONAL LICENSES

State		License No.		Expiration Date (MM/YYYY)	
State		License No.		Expiration Date (MM/YYYY)	

Medicare ID No.		ECFMG No.		☐ or NA
UPIN		Individual BCBSM No.		HIPAA Taxonomy Codes
National Provider Identification No. (NPI)		CHAMPS Domain Administrator/Phone Number		

BOARD CERTIFICATION (Attach additional sheet if necessary)

Are you board or otherwise professionally certified?

☐ **YES** If "yes", please complete below ☐ **NO** If "No", describe your intent for certification, if any, and dates of testing for certification on a separate sheet. If you participate in a specialty which does not have board certification, please indicate on a separate sheet.

Name of Issuing Board	Specialty	Date Certified/Recertified	Expiration Date (if any)

OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS, etc. (Attach copy of certificate if applicable)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

SECTION 5 – PROFESSIONAL REERENCES

PROFESSIONAL REFERENCES/LETTERS OF RECOMMENDATION

List three professional references not including relatives, your own employees, and not provided by the head or member of the department/specialty office to which you are applying. They must attest to your medical knowledge, research experience (if applicable), clinical skills and professionalism, and have been written within the last two years from your proposed start dates at the CMU College of Medicine. At least one reference must be an individual practicing in a similar field.
NOTE: References must be from individuals who, through recent observation, are directly familiar with your work. ***References for CMU Medical Education Partners trained applicants cannot be from the director of the program for which they are applying.***

Name	Title	Telephone Number
Address (street, city, state, zip code)		Fax Number
Name	Title	Telephone Number
Address (street, city, state, zip code)		Fax Number
Name	Title	Telephone Number
Address (street, city, state, zip code)		Fax Number

SECTION 6 – PROFESSIONAL LIABILITY

PROFESSIONAL LIABILITY CARRIER INFORMATION

Does your current professional liability insurance cover you in all of your practice locations? ☐ YES ☐ NO

Current Insurance Carrier				Policy No.	
Address (street, city, state, zip code)				Telephone Number	
Coverage Amount (Claim/Aggregate)	Type of Coverage			Exclusions from Coverage	
Initial Date of Coverage	Retroactive Date of Coverage			Expiration Date	

Please list all of your professional liability carriers for the **past ten years** (include internship, residency, fellowship programs).

Name of Carrier				Policy No.	
Address (street, city, state, zip code)					
Telephone Number		From		To	
Name of Carrier				Policy No.	
Address (street, city, state, zip code)					
Telephone Number		From		To	
Name of Carrier				Policy No.	
Address (street, city, state, zip code)					

Telephone Number		From		To	

SECTION 7 – ATTESTATION QUESTIONS

Please answer the questions "yes" or "no". **If your answer to any of the questions 2-17 is "yes", please provide full details and reasons on a separate sheet.**

An affirmative answer to any of these questions does not automatically disqualify you from an appointment at the CMU College of Medicine but may result in further follow-up or investigation for credentialing purposes.

NOTE: All information is for credentialing purposes only. Information will remain confidential and will not be shared.

1)	Are you currently able, with or without reasonable accommodation, to perform delineated clinical activities and other House Staff duties?	☐ YES ☐ NO
2)	Do you have or have you ever had any license revoked, suspended, denied, restricted, limited or issued/placed in a probationary status or voluntarily relinquished?	☐ YES ☐ NO
3)	Have you ever had a DEA Certificate revoked, suspended, limited, restricted in any way or voluntarily relinquished?	☐ YES ☐ NO
4)	Have you ever voluntarily not renewed your DEA license, Medical or Dentistry License in any state?	☐ YES ☐ NO
5)	Have you ever been terminated, placed on probation or otherwise disciplined from a residency program or medical staff?	☐ YES ☐ NO
6)	Have your privileges at any hospital ever been refused, suspended, diminished, revoked or not renewed?	☐ YES ☐ NO
7)	Have you ever voluntarily withdrawn your privileges or resigned from any hospital or training program?	☐ YES ☐ NO
8)	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization?	☐ YES ☐ NO
9)	Have you ever been named in a malpractice case?	☐ YES ☐ NO
10)	Are you now, or have you ever been, involved in Administrative, professional, or judicial proceedings in which malpractice on your part is or was alleged? **If "yes", please complete the enclosed SUPPLEMENTAL CLAIMS INFORMATION FORM for each claim.**	☐ YES ☐ NO
11)	Have you ever been subject to disciplinary action for academic or other reason in any of the colleges, universities, graduate or professional schools you have attended?	☐ YES ☐ NO
12)	Have you ever been convicted of a crime other than minor traffic violations?	☐ YES ☐ NO
13)	Have you ever been convicted of a felony?	☐ YES ☐ NO
14)	Are you aware of any criminal charges pending or expected to be brought against you?	☐ YES ☐ NO
15)	Do you have any contagious or communicable diseases that could endanger others?	☐ YES ☐ NO
16)	Have you ever been addicted to or dependent upon intoxicating liquor, narcotics or other illegal drug substances?	☐ YES ☐ NO
a)	Has this addiction ever permanently, presently or chronically impaired or distorted your judgment, behavior, or capacity to recognize reality or ability to cope with the ordinary demands of life?	☐ YES ☐ NO

17)	Are you delinquent on any Federal debt? (Include delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults on any Federally guaranteed or insured loans such as student or home mortgage loans).	☐ YES ☐ NO

SECTION 8 – ATTESTATION, AUTHORIZATION AND RELEASE AND ACKNOWLEDGEMENT OF TRAINING AND EDUCATION RESPONSIBILITY

CONSENT AND RELEASE

In applying for appointment at the CMU College of Medicine, I have read and agree to abide by its Medical Staff Bylaws. I certify that the statements in this application are true and complete and I understand and agree that misstatements or omissions in this application may be grounds for summary dismissal from the staff. I agree to immediately report any changes in the status of my medical license or any changes in my status at other hospitals, to the office of academic appointments.

I will be responsible for the medical care of the patient, for prompt and accurate completeness of medical records, for transmitting reports of the patient's condition to concerned parties who are entitled to such information, and for providing or appropriately arranging for continuity of care.

I agree to report any changes in my health status that could adversely affect my ability to practice medicine and agree, with reasonable cause, to submit to a physical examination, drug and alcohol screens and other assessments acceptable to the Executive Committee should this be considered necessary.

If I am ever under investigation by any regulatory agency (e.g., the State of Michigan Department of Consumer and Industry Services), I am responsible for immediately informing the office of academic appointments of the agency involved, the basis for the complaint and the final resolution or outcome.

I recognize ***it is my responsibility, and mine alone***, to maintain appropriate licensure at all times. I agree to abide by all rules and regulations regarding same and I realize it is unlawful to practice medicine without an active license.

I hereby authorize agents of the University to consult with other universities, hospitals and members of their medical staffs, and with licensing boards, and with anyone who may have information bearing on my competence, my character or my ethical qualification. I further authorize agents of the University to make inquiries from the said individual hospitals, boards, and courts concerning any claims, lawsuits, disciplinary actions, license restrictions or denials, or any other matters affecting my ability to practice my profession. I hereby consent to the release from any source, including information that would otherwise be privileged or confidential, to the CMU College of Medicine, of any and all information concerning my conduct and abilities to practice.

I hereby authorize and release from liability, the CMU College of Medicine and all managed care organizations or other third party payers, insofar as the University provides information from my credentialing file, including information that is confidential and/or privileged, or permits access to my file to such other organizations or payers with a need to independently evaluate or verify my credentials, or audit CMU College of Medicine's credentialing process and decisions.

I hereby release from liability all individuals and organizations that provide information concerning my qualifications for appointment. I further release from liability the CMU College of Medicine, its staff, officers and employees who make inquiries concerning my conduct and abilities to practice, and I hereby indemnify them from any claim arising from their consideration, award or denial of my application.

I certify that the information submitted on this application is complete and correct to the best of my knowledge. I understand that any false, misleading or missing information may be cause for withdrawal of the preliminary appointment.

Signature _____ Date: _____

Printed Name _____

SUPPLEMENTAL CLAIMS INFORMATION FORM **N/A ☐ If no claims.**

(PLEASE COMPLETE A SEPARATE FORM FOR EACH CLAIM)

Claim Number or Patient Initials:_____ Age:_____ Gender: _____

Incident Is: ☐Pending Date_____ Closed Date: _____

☐Dismissed Date_____

☐Settlement Date_____ $ _____

☐Judgment Date_____ $ _____

You Are: ☐ Solo Defendant

☐ Co-Defendant With _____

☐ Other _____

Were the Settlement Terms Confidential? ☐ Yes ☐ No

Settlement/Judgment Details:_____

Amount Paid on Your Behalf: _____

Date of Incident: _____ Date Suit Filed: _____

Court: _____ Case No.: _____

Name and Address of Insurance Carrier at Time of Incident: _____

Name of Additional Defendant(s):_____

Explain in Detail the Plaintiff's Allegations: _____

Explain in Detail your Defenses to These Allegations: _____

Patient's Condition Post-Incident: _____

Whom may we consult for further legal information about the suit:_____

_____ _____

Signature of Applicant Date

_____

Print Name

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