



MOUNT CARMEL
East, West and St. Ann's

A MEMBER OF TRINITY HEALTH

**MEDICAL STAFF
PRE-APPLICATION**

Please complete the following information and return via fax to the Medical Staff Office at either St. Ann's Hospital: (614) 898-8680, or Mount Carmel: (614) 234-8132.

IMPORTANT POINTS OF INFORMATION:

- Mount Carmel Health (East/West) and St. Ann's are separate medical staffs that share credentialing processes that may require some hospital specific documents be completed.
- Certification by an ABMS/AOA recognized Board, (or Board Qualified) is required by both medical staffs. Requirements are specialty specific.
- Malpractice Insurance carrier must have no less than a "B+" rating, such as that provided by the AM Best rating service, with \$1mil/\$3mil minimum coverage.
- ER Call participation may be required.
- Non-refundable application fees (Submitted with formal application): Mount Carmel Health (\$425); St. Ann's (\$400)

Requesting application for: **Mount Carmel East/West** _____ **Mount Carmel St. Ann's** _____

Do you have an updated Ohio Department of Insurance (ODI) form? YES NO

NAME: _____ SSN: _____ DOB: _____

MAILING ADDRESS: _____

CONTACT PERSON: _____ PHONE: _____ FAX: _____

SPECIALTY: _____

MEDICAL/DENTAL/PODIATRIC SCHOOL: _____ DATES: _____

INTERNSHIP: _____ DATES: _____
TYPE: _____

RESIDENCY: _____ DATES: _____
TYPE: _____

FELLOWSHIP: _____ DATES: _____
TYPE: _____

CURRENT STATE MEDICAL LICENSE:
STATE: _____ LICENSE: # _____ EXP. DATE: _____

DEA CERTIFICATE: # _____ EXP. DATE: _____

NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI) _____

MALPRACTICE INSURANCE CARRIER _____

CERTIFICATION BY AMERICAN BOARD OF SPECIALTY: (Name and date of certification) _____

1. Do you, or any non-publicly owned organization in which you own any interest, or any co-owner of any such organization, directly or indirectly own an investment interest in a healthcare facility (existing or proposed) that provides in-patient hospital beds or services in Franklin or any contiguous county in Ohio?

_____ **Yes** _____ **No**

If yes, please explain _____

2. Does any organization with which you have a compensation arrangement directly or indirectly own an investment interest in a healthcare facility (existing or proposed) that provides in-patient hospital beds or services in Franklin or any contiguous counties in Ohio?

_____ **Yes** _____ **No**

If yes, please explain _____

All information submitted above is true and complete to my best knowledge and belief. I understand that any material misstatement in or omission constitutes cause for refusing to send me an appointment application.

Printed Name

Applicant's Signature

Date