El Camino Health

Pre-Application/Intent to Practice Questionnaire

Thank you for your interest at El Camino Hospital. New applicants must meet the basic qualifications listed below.

****Please provide a copy of curriculum vitae and 24 month activity log at submission of pre-application.****

Basic Qualifications for El Camino Hospital

Please answer each of the following questions.	**Yes**	**No**
In the last 7 years, voluntary or involuntarily, have any of the following ever been or are currently being denied, revoked, suspended, relinquished, withdrawn, reduced, limited, placed on probation, not renewed, or currently pending/under investigation?		
Medical/Psychology license, other professional registration/license or certificate of registration including but not limited to DEA? **(if yes, please provide a written explanation)**	☐	☐
Academic appointment or employer? **(if yes, please provide a written explanation)**	☐	☐
Membership on any hospital staff or clinical privileges prerogatives/rights on any medical staff? **(if yes, please provide a written explanation)**	☐	☐
Have you been convicted of a felony or misdemeanor (other than a minor traffic violation)? **(if yes, please provide a written explanation)**	☐	☐
Board certification or any other type of professional sanction? **(if yes, please provide a written explanation)**	☐	☐
Are you board certified in your primary specialty or if recently completed residency/fellowship, will become board certified within five (5) years of completion of residency/fellowship? **(if no, please provide written explanation)**	☐	☐
Have you actively practiced within the past 24 months? **(if no, please provide written explanation)**		

If you meet the basic qualifications for membership, information to submit an electronic application will be sent to you via the e-mail address you provided. Please allow **5 working days** for the processing of your pre-application. Please print clearly:

First Name: _____ Middle Name: _____

Last Name: _____ Degree: _____ Gender_____

SSN: _____ DOB: _____

Mobile/Cell Number: _____ E-mail Address: _____

Medical/Training School: _____ City_____ State_____ Zip_____
Graduation Year: _____

If you recently completed training, please indicate what specialty and when: _____

Board/s/Certification/s: (If applicatble):_____

Ca. Medical License Number:_____ DEA_____ NPI_____

Work Address: _____ City_____ State_____ Zip_____

Primary Campus: _____ Mountain View _____ Los Gatos

Who is your covering physician? (For AHPs, please provide name of supervising Physician.)_____

To what extent do you anticipate using the facilities at El Camino Hospital?

_____

Requested Start Date? (Please allow 90-120 days for standard processing.) _____

Signature / Date: _____

Please return along with CV and 24 month activity log via e-mail (medstaff@elcaminohospital.org) or by fax (650-966-9263).

If you have any questions regarding application process, you may contact the Medical Staff Office at the MV Campus 650-940-7040 or LG Campus 408-866-4007.

El Camino Health

Medical Staff Services 2500 Grant Road 1C35 Mountain View CA, 94040

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that the El Camino Hospital Medical Staff is responsible for the evaluation of my professional competence and qualifications, and has the obligation to inquire into my professional training, experience, professional conduct and judgment, and to make appropriate recommendations to the Board of Directors.

I recognize that inquiries will be made as part of this credentialing process. I consent to these inquiries and to the release of information bearing upon my professional qualifications to this staff and facility by persons, hospitals, medical staffs, medical groups, peer review organizations, professional societies, training programs, professional associations, insurance companies, licensing authorities, and others for the purpose of determining my present and future qualifications for Medical Staff membership and privileges. This authorization includes inspection and copying of all records and documents, including medical records at other hospitals that may be material to an evaluation of my professional qualifications and competence, as well as my moral and ethical qualification for staff membership.

I authorize and request my professional liability insurance carriers, past and present, to release any and all information concerning, but not limited to, malpractice ratings, claims, settlements and judgments in which I have been involved. Further, I request my insurance carrier to give notice to this facility of any cancellation or change in my professional liability coverage and also request the issuance of a certificate of insurance for this application.

This is to authorize El Camino Hospital, and its representatives to provide any and all information and documentation that may be requested regarding my professional qualifications. This authorization specifically includes, but is not limited to, any and all information and documentation relating to my clinical competence, my professional conduct, and/or any peer review activities involving me during my tenure on the Medical Staff.

I release from liability all persons or entities which participate in the evaluation of this application and which request or provide information regarding this application and my qualification in general. This release from liability is to the fullest extent allowed by applicable law including, but not limited to, Sections 43.7, 43.8, and 47 of the California Civil Code.

I understand that any significant misstatements or omissions by me during this credentialing process will be sufficient cause for decision to deny my application or not to proceed with its consideration; the information furnished by me is true and complete to the best of my knowledge.

— I hereby consent and agree to the terms in the “Authorization for Release of Information” above.

Electronically signed by:

El Camino Health

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