CEDARS-SINAI MEDICAL CENTER (REV. 11-10-08-GME 11-2-21) *Physician Application Form* *GRADUATE MEDICAL EDUCATION*	
Name	Phone Number
Program	

INSTRUCTIONS: Applicant must fill out the application in its entirety. In no area of the form does the statement "See CV" meet the requirements for a completed application.

THIS APPLICATION CANNOT HAVE ANY BLANK OR UNADDRESSED AREAS OR IT MAY BE RETURNED TO YOU AS INCOMPLETE.

Confidential Mailing Address and Confidential E-mail Address: ***Please indicate where you want to receive Confidential Business Correspondence. Non-confidential correspondence will be sent to your office address unless indicated in the box below:***

Confidential Email Address (preferred method of communication)		
Confidential Mailing Address (PO Boxes not allowed due to delivery restrictions)		
City	State	Zip Code
☐ Please send ALL mail correspondence to the address listed above and not to my office address		

Office: ***Identify Your Primary Practice Site***

Office Name	
Office Street Address	Office Phone 1
Office City, State, Zip	Office Phone 2
Office Contact/Office Manager	Office Fax

Personal Information

Last Name	First Name		Middle Name or Middle Initial
Other Names By Which You Have Been Known Professionally		Degree	Social Security Number
Home Street Address		Home City/State/Zip	
Home Phone Number	Pager		Cell Phone
Date of Birth	Sex ☐ Male ☐ Female		Birth City/State
Birth Country	Citizenship		Ethnic Origin (optional)
Languages Spoken by Applicant			

***Hospital Affiliations**: List all hospitals and institutions where you have ever had an affiliation since graduation from medical school. Indicate affiliation status (Active, Courtesy, Provisional, Temporary, Other, etc.). Begin with current affiliations and then list past affiliations.*

Hospital Name		Start Date / /	End Date / /
Street Address		City, State and Zip Code	
Medical Staff Services Dept. Phone Number	Medical Staff Services Dept. Fax Number	Affiliation Status	
Department			
Hospital Name		Start Date / /	End Date / /
Street Address		City, State and Zip Code	
Medical Staff Services Dept. Phone Number	Medical Staff Services Dept. Fax Number	Affiliation Status	
Department			
Hospital Name		Start Date / /	End Date / /
Street Address		City, State and Zip Code	
Medical Staff Services Dept. Phone Number	Medical Staff Services Dept. Fax Number	Affiliation Status	
Department			
Hospital Name		Start Date / /	End Date / /
Street Address		City, State and Zip Code	
Medical Staff Services Dept. Phone Number	Medical Staff Services Dept. Fax Number	Affiliation Status	
Department			
Hospital Name		Start Date / /	End Date / /
Street Address		City, State and Zip Code	
Medical Staff Services Dept. Phone Number	Medical Staff Services Dept. Fax Number	Affiliation Status	
Department			
Hospital Name		Start Date / /	End Date / /
Street Address		City, State and Zip Code	
Medical Staff Services Dept. Phone Number	Medical Staff Services Dept. Fax Number	Affiliation Status	
Department			

Education and Training

Medical Education or Professional School

Name Of Institution			Start Date / /	Finish Date / /
Complete Address				
Phone Number	Fax Number	E-Mail Address	Degree Obtained	
Name Of Institution			Start Date / /	Finish Date / /
Complete Address				
Phone Number	Fax Number	E-Mail Address	Degree Obtained	

Internship (if applicable)

Name Of Institution			Start Date / /	Finish Date / /
Complete Address			Program Director Name	
Phone Number	Fax Number	E-Mail Address	Specialty	

Residency

Name Of Institution			Start Date / /	Finish Date / /
Complete Address			Program Director Name	
Phone Number	Fax Number	E-Mail Address	Specialty	
Name Of Institution			Start Date / /	Finish Date / /
Complete Address			Program Director Name	
Phone Number	Fax Number	E-Mail Address	Specialty	

Fellowship

Name Of Institution			Start Date / /	Finish Date / /
Complete Address			Program Director Name	
Phone Number	Fax Number	E-Mail Address	Specialty	
Name Of Institution			Start Date / /	Finish Date / /
Complete Address			Program Director Name	
Phone Number	Fax Number	E-Mail Address	Specialty	

Additional Training, such as Preceptorships, etc.

Description of Training Program			Start Date / /	Finish Date / /
Training Program Director Name		Complete Address of Training Program Director		
Phone Number	Fax Number	E-Mail Address		
Description of Training Program			State Date / /	Finish Date / /
Training Program Director Name		Complete Address of Training Program Director		
Phone Number	Fax Number	E-Mail Address		

Board Certified Specialty: ***Enter specialties and subspecialties in which you have become board certified or have been re-certified. Include the year of the initial certification or last re-certification, and the date of expiration.***

Board Certification Name, Specialty and Subspecialty	*Year Certified / Recertified*	*Expiration Date*

Clinical Teaching Appointments: ***List current and previous clinical teaching appointments.***

Name Of Institution			Supervisor's Name	
Complete Address			Start Date / /	Finish Date / /
Phone Number	Fax Number	E-Mail Address	Job Title	
Name of Institution			Supervisor's Name	
Complete Address			Start Date / /	Finish Date / /
Phone Number	Fax Number	E-Mail Address	Job Title	

Employment: ***List all current and previous employers since medical school graduation including periods of self-employment.***

Employer Name			Supervisor's Name	
Complete Address			Start Date / /	Finish Date / /
Phone Number	Fax Number	E-Mail Address	Job Title	
Brief Description of Job Responsibilities _____				
Employer Name			Supervisor's Name	
Complete Address			Start Date / /	Finish Date / /
Phone Number	Fax Number	E-Mail Address	Job Title	
Brief Description of Job Responsibilities _____				
Employer Name			Supervisor's Name	
Complete Address			Start Date / /	Finish Date / /
Phone Number	Fax Number	E-Mail Address	Job Title	
Brief Description of Job Responsibilities _____				

Explanation of Work History Gap: ***Any time periods or gaps since graduation from medical school of greater than 60 days which are not explained in the application thus far, must be addressed here. If the application is found to have any unexplained time periods or gaps since medical school of greater than 60 days, the application will be considered incomplete until such time as the information is provided. Please explain any such gaps in the space provided below.***

From Date	To Date	Explanation of Gap
		_____ _____
		_____ _____
		_____ _____

ID Numbers

State Licensure: ***List all current and past state licenses.***

State of Licensure	*Number*	*Type*	*Expiration Date*

Other ID Numbers

DEA Number: _____ ☐ I am attesting that my DEA has a California address and full schedule (22N 33N 4 5) as required by Cedars-Sinai Medical Center.			DEA Expiration
NPI Number:	UPIN Number:	ECFMG Number:	ECFMG Date Issued:

Authoritative Source:

1. If you completed formal training within the last three (3) years, provide the name of your training director;
OR
2. If you completed formal training more than three (3) years ago, provide the name of the Department Chair or Chief at the hospital where you are most active and currently exercise clinical privileges, who can attest to your current clinical competence and professional performance during the past two (2) years.

Reference Name and Title	Specialty	Phone Number
Complete Address		Fax Number

Attestation Questions: ***Please answer the following questions "yes" or "no." If your answer to questions A through K is "yes," or if your answer to L is "no," please provide full details on separate sheet.***

A.	Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?	☐ Yes ☐ No
B.	Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?	☐ Yes ☐ No
C.	Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, placed in abeyance (military), revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending.	☐ Yes ☐ No
D.	Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?	☐ Yes ☐ No
E.	Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	☐ Yes ☐ No
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?	☐ Yes ☐ No
G.	Have you been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?	☐ Yes ☐ No
H.	Have you ever been convicted or pleaded guilty or nolo contendere to any crime (other than a minor traffic violation)?	☐ Yes ☐ No
I.	Do you presently use any drugs illegally?	☐ Yes ☐ No
J.	Have any judgments been entered against you, or settlements been agreed to by you within the last eight (8) years, in professional liability cases, or are there any filed and served professional liability lawsuit/arbitrations against you pending? **IF YOU ANSWER "YES," PLEASE PROVIDE DETAILED INFORMATION ON THE ENCLOSED FORM.**	☐ Yes ☐ No
K.	Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?	☐ Yes ☐ No
L.	**Are you able to perform all the requested clinical privileges and comply with all the requirements of the Cedars-Sinai Medical Center Medical Staff Bylaws and Policies and Procedures to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance, without posing a direct threat to the safety of patients?** PLEASE TO PROVIDE FURTHER DETAIL ON THE ENCLOSED FORM.	☐ Yes ☐ No

Name (please print or type) _____ Practitioner Signature (Stamped Signature Is Not Acceptable) _____ Date _____

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this application and any re-credentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities requesting or providing peer review and credentialing information from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law. I further release from liability any persons or entities that take any action on my application or my Medical Staff privileges or membership, so long as the action was taken in good faith, after a reasonable investigation.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et seq., if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or non-renewal of my license to practice medicine in California; (ii) any suspension, revocation or non-renewal of my DEA or other controlled substances registration; or (iii) any cancellation or non-renewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I understand that a copy of this release may be provided to other individuals or entities.

Name (please print or type)	Practitioner Signature (Stamped Signature Is Not Acceptable)	Date

CONFIDENTIAL REPORT OF PHYSICAL AND MENTAL DISABILITIES

(TO BE SUBMITTED TO THE WELL-BEING COMMITTEE FOR SEPARATE PROCESSING)

PHYSICAL AND MENTAL HEALTH STATUS		
A. Do you have any physical or mental disability which impairs or could impair your ability to carry out your professional obligations in a manner that meets the standards of care in the community and the Bylaws, Rules and Regulations and Policies of this Healthcare Organization? (When answering this question, please consider all types of physical or mental disability, including past or present substance abuse.)	**YES**	**NO**
B. Considering the essential functions of a practitioner in your area of practice, are you suffering from any communicable health condition that could pose any significant health and safety risk to your patients?	**YES**	**NO**
C. In the past five years, up to and including the present, have you had a history of chemical dependency or substance abuse that might adversely affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?	**YES**	**NO**
D. If you answered A, B, or C yes, could accommodations be made to allow you to practice at the Healthcare Organization?	**YES**	**NO**

If you answered "Yes" to any question on this page, please describe all physical and/or mental disabilities you have which impair or could impair your ability to carry out your professional obligations in a manner that meets the standards of care in the community ad the Bylaws, Rules and Regulations and Policies of this Healthcare Organization and the accommodations that could be made to enable you to practice at the Healthcare Organization.

Name (please print or type) | Practitioner Signature | Date