Hutcheson
100 Gross Crescent Circle | Fort Oglethorpe, Georgia 30742 | P: 706.858.2000 | www.hutcheson.org

Dear Physician:

Thank you for your interest in Hutcheson Medical Center. We would like to take this opportunity to tell you about our application process, should you wish to apply for membership/privileges at our facility. Emergency Medicine, Anesthesia, Pathology & Radiology are exclusive services available only through the groups contracted. No independent applications will be accepted.
The following is a minimum bylaw requirement that must be met to be eligible for Medical Staff Membership and/or privileges.

Your primary practice or legal residence must be within a 30-mile radius of Hutcheson Medical Center.

Credentialing new applicants is a two step process at HMC. The first step is preparation of the pre-application form and returning it to the Medical Staff Office within two (2) weeks to the following:

Medical Staff Office
Hutcheson Medical Center
100 Gross Crescent Circle
Ft. Oglethorpe, GA 30742

After review for eligibility, which includes verification of current licensure, competency, etc., an application will be mailed to you from TPQVO, our contracted central verification organization. The second step is submission of the actual application to TPQVO. Verification of the application and its content will take up to 90 days.

Should you have any questions, or would like to contact the Medical Staff Office to request a pre-application, please contact me at (706) 858-2108.

Sincerely,

Kelley Dotson RN, BSN

Kelley Dotson, RN, BSN
Quality Management Coordinator
Medical Staff / Quality Assurance

HUTCHESON MEDICAL CENTER
PREAPPLICATION FORM-REQUEST FOR MEDICAL STAFF APPLICATION FORM

(Please type or legibly print the information requested)

NAME:_____
First Middle Last

DATE OF BIRTH:_____ SOCIAL SECURITY #_____

OFFICE ADDRESS:_____
Street City State Zip Code

OFFICE TELEPHONE:_____ RESIDENCE TELEPHONE:_____

RESIDENCE ADDRESS:_____
Street City State Zip Code

(1) Please indicate your clinical specialty as well as any areas in which you may wish to request clinical privileges.

SPECIALTY

_____Allergy and Immunology
_____Anesthesiology
_____Cardiovascular-Thoracic Surgery
_____Oral and Maxillofacial Surgery
_____Dentistry
_____Emergency Medicine
_____Endocrinology
_____Diagnostic Radiology
_____Family Practice
_____Gastroenterology
_____General Surgery
_____Hematology
_____Infectious Disease
_____Internal Medicine
_____Medical Oncology
_____Neonatology
_____Neurology
_____Obstetrics and Gynecology
_____Occupational Medicine
_____Ophthalmology
_____Orthopedic Surgery
_____Otolaryngology
_____Pathology
_____Pediatrics
_____Physical Medicine & Rehabilitation
_____Plastic and Reconstructive Surgery
_____Podiatry
_____Psychiatry
_____Pulmonary Medicine
_____Radiation Oncology
_____Rheumatology
_____Urology
_____Other

(2) To what extent do you anticipate using the facilities of the Hutcheson Medical Center (Approximate number per year)?

(a) Admissions _____
(b) Outpatient Procedures _____
(c) Inpatient Procedures _____
(d) Consultations _____
(e) Percentage of your total practice _____ %

(3) Do you plan to establish or have you established an office near the hospital?
Yes___ No___

(4) Have any disciplinary actions or investigations been initiated or are pending against you by any State licensure board?
Yes___ No___

(5) Has your license to practice in any state ever been relinquished, denied, limited, suspended, revoked or voluntarily relinquished?
Yes___ No___

(6) Have you ever been asked to surrender your license?
Yes___ No___

(7) Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (for example, Medicare, Medicaid)?
Yes___ No___

(8) Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance programs?
Yes___ No___

(9) Has your narcotics registration certificate ever been relinquished, limited, suspended, revoked, or voluntarily relinquished?
Yes___ No___

(10) Have you ever been named as a defendant in any criminal proceedings?
Yes___ No___

(11) Have your employment, Medical Staff appointment, or clinical privileges ever been voluntarily or involuntarily suspended, diminished, revoked, refused, relinquished, or limited (except for failure to complete medical records) at any hospital or other health care facility?
Yes___ No___

(12) Are you planning to apply for appointment and clinical privileges at any other hospital?
Yes_____ No___

Hospital:_____ Address:_____

Hospital:_____ Address:_____

Hospital:_____ Address:_____

(13) List three professional peer references who have had first-hand observation and otherwise, that you are highly qualified in regard to your:

(a) background, experience, training, and demonstrated competence;
(b) adherence to the ethics of profession;
(c) reputation and character;
(d) ability to safely and competently exercise the requested clinical privileges;

(e) ability to work harmoniously with others sufficiently to convince the System that all patients treated at the System will receive quality care, and that the System and its medical staff will be able to operate in an orderly manner.

(1) _____

Name Title Phone Number

_____

Street City State Zip Code

(2) _____

Name Title Phone Number

_____

Street City State Zip Code

(3) _____

Name Title Phone Number

_____

Street City State Zip Code

(14) This form must be returned with copies of the following documents:

(a) Current Georgia license to practice medicine;
(b) DEA certificate;
(c) Professional liability insurance policy certificate of coverage from insurance carrier;
(d) ECFMG certificate (if foreign medical graduate);
(e) A curriculum vitae, which will become part of your file;

(15) Have you actively practiced in your field of medicine full time at least 12 months within the past 24 months?_____ Yes _____ No

I request an application for appointment to the medical staff of Hutcheson Medical Center. I understand that completing this Pre-Application in no way obligates the hospital and/or medical staff to afford me medical staff membership or privileges.

As an applicant for staff appointment and privileges, I understand that it is my responsibility to produce adequate information so Hutcheson Medical Center can perform a proper evaluation of my application. I agree to provide Hutcheson Medical Center System with updated information regarding all questions on this pre-application form as new information becomes available. I also agree to provide Hutcheson Medical Center with additional information that one of its authorized representatives may request. Failure to produce any requested information will prevent my application from being processed.

As part of this request for application, I authorize Hutcheson Medical Center to obtain references on my qualifications and current clinical competence.

_____

Signature

_____

Date