APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

Hospital	Location	Date
MANATI MEDICAL CENTER	MANATI, PUERTO RICO	

IDENTIFYING INFORMATION	Last Name	First Name	Initial	SSN	Birthplace	Date of Birth
	Email:					
	Address	City	State	Zip Code	Phone or Cell	
	Citizenship	Marital Status ☐ M ☐ S ☐ W ☐ D		Name of Spouse		

PREMEDICAL EDUCATION	College or University	Degree	Honors
	Address		Date of Graduation
MEDICAL EDUCATION	Medical School	Degree	Honors
	Address		Date of Graduation
INTERNSHIP	Hospital	Address	
	Type of Internship		Dates
RESIDENCIES	Fellowships, Preceptorships, Teaching Appointments, Postgraduate Education (chronological order: Dates, Locations, Chiefs of Staff, Chairmen of Departments and other practitioners responsible for performance)		
	Location		Dates
	Location		Dates
	Location		Dates
AFFILIATIONS	List all present and previous hospital affiliations and medical staff memberships, in chronological order (include assistantships and appointments). Specify all departments in which privileges were exercised.		
	Name and Location of Hospital	Status	Dates
	Name and Location of Hospital	Status	Dates
	Name and Location of Hospital	Status	Dates
	Name and Location of Hospital	Status	Dates
MEMBERSHIP IN PROFESSIONAL SOCIETIES	Colegio Médico Cirujanos de Puerto Rico ☐ Yes ☐ No		Dates
	Other		Dates
	Other		Dates
FELLOWSHIP	American Board of		Dates
	American Board of		Dates
	Fellowship in Other Specialty Colleges		Dates

Date

Signature of Applicant

CERTIFICATION	Are you Certified? ☐ Yes ☐ No		Dates (From / To)
	Certified by American Board of (Name of Board)		
	Board Qualified (Name of Board)		
LICENSING	Puerto Rico Medical License Number	Register No.	Date
	Other Medical License State and County	Register No.	Date
	Puerto Rico Narcotics Registration Number		Date
	Federal Narcotics Registration Number		Date
MEDICAL REFERENCES	Doctor	Address	Phone or Cell
	Doctor	Address	Phone or Cell
	Doctor	Address	Phone or Cell
	Doctor (Member of Manatí Medical Center Medical Faculty)	Address	Phone or Cell
LIABILITY INSURANCE	Amount of Coverage	Insurance Carrier	
	Policy No.	Expiration Date	
	Have judgment or settlements been made against you in professional liability cases, Or are there any pending? If yes, give details on separate sheet.		Yes ☐ No ☐

IF ANSWER TO ANY OF THE FOLLOWING QUIESTIONS IS YES, PLEASE GIVE FULL DETAILS ON SEPARATE SHEET

a. Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked? Yes ☐ No ☐
b. Have you ever been refused membership on a hospital medical staff? Yes ☐ No ☐
c. Has your request for any specific clinical privileges ever been denied, or granted with stated limitations? Yes ☐ No ☐
d. Have your privileges at any hospital ever been suspended, diminished, revoked, not renewed or voluntarily renounced (other than inactivity)? Yes ☐ No ☐
e. Has your narcotics registrations ever been suspended or revoked? Yes ☐ No ☐
f. Have you ever been denied membership or renewal thereof, or been subject to disciplinary actions in any medical organization? Yes ☐ No ☐

I HEREBY APPLY TO THE HOSPITAL FOR APPOINTMENT	Category you want to apply: ☐ Active ☐ Consulting ☐ Courtesy ☐ Honorary (Emeritus) Specify Specialty or Sub-Specialty Consultation (if applicable):			
PRIVILEGES DESIRED AND REQUESTED	☐ Anesthesia ☐ Dental ☐ Emergency Room ☐ Family Medicine	☐ Internal Medicine ☐ Nuclear Medicine & Radiotherapy ☐ Obstetrical & Gynecological	☐ Orthopedic ☐ Pathology ☐ Pediatric ☐ Radiology	☐ Surgical ☐ Other (specify) _____ _____
SPECIFIC PRIVILEGES	Other Specific Privileges & Special Procedures (not included as Core Privileges in your Specialty) requested are detailed on separate sheet ☐ No ☐ Yes, and supporting education certificates are supplied			

I fully understand that any significant misstatements in or omissions form this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true to my best knowledge and belief.

Date _____ Signature of Applicant _____