UNIVERSITY OF MARYLAND MEDICAL CENTER MIDTOWN CAMPUS
CREDENTIALING APPLICATION ADDENDUM

University of Maryland Medical Center Midtown Campus (UMMC Midtown Campus) requires applicants for appointment and clinical privileges to supplement the Maryland Hospital Credentialing Application with information set forth below.

1. In addition to any training listed in Section 3 of the Credentialing Application, please list below each and every internship, residency, or fellowship that you began, but did not successfully complete. If there are no such training programs, please indicate that by writing, "not applicable." If you need additional space, please use a separate piece of paper.

   Institution:_____

   Dates:_____ to _____
   (month\year) (month\year)

   Address:_____

   Program Director: _____

   Type of Internship/Residency/Fellowship:_____

2. Please provide the name, address, and dates of membership for all local, state and national professional societies.

   _____
   _____
   _____

3. Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings, in any professional organization? Yes _____ No____ *If "yes" please provide a full explanation of the details on a separate sheet and attach.*

4. Has any insurance carrier ever imposed a surcharge or additional premium upon you because of your malpractice action history? Yes_____ No _____

5. In regard to section VIII. G. of the Credentialing Application, please list all professional liability carriers for the last ten years.

6. 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 program? Yes_____ No_____. *If "yes" please provide a full explanation of the details on a separate sheet and attach.*

7. In Section XI of the Credentialing Application under "Professional References," please list at least two professional references, not including relatives, current partners, or associates in practice who have had recent extensive experience in observing and working with you. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you. At least one reference must practice in your clinical specialty.

8. Please indicate the clinical privileges that you are requesting by completing the attached clinical privilege form.

9. If not previously provided, please attach copies of the following documents to your application:
   (a) ECFMG certificate, if foreign medical graduate.
   (b) Current curriculum vitae.

10. Conditions of Application, Release and Immunity.

CONDITIONS OF APPLICATION

In return for my application being considered and processed, I agree to be legally bound by the following terms and conditions.

1. I understand that it is my responsibility to produce adequate information so that my application can be properly evaluated. In addition to the information provided in this application, I also agree to provide UMMC Midtown Campus with any additional information that UMMC Midtown Campus or one of its authorized representatives may request. MY FAILURE TO PROVIDE ANY REQUESTED INFORMATION WILL CAUSE MY APPLICATION TO BE INCOMPLETE AND WILL PREVENT IT FROM BEING PROCESSED.

2. I also agree to keep this application current by informing UMMC Midtown Campus, through the Chief Executive Officer, or his or her designee, of any changes in the information provided, including, but not limited to, any investigations by a state licensing agency, any change in my professional liability insurance coverage, the filing of a professional liability lawsuit against me, any change in my status at any other hospital, any change in my eligibility for participation in the Medicare or Medicaid programs, and any change in my ability to safely and completely exercise my clinical privileges because of health status issues, including impairment.

3. I will make myself available for interviews in regard to this application.

4. I agree to accept committee assignments, emergency service call obligations, and such other reasonable medical staff duties and responsibilities as shall be assigned to me.

5. I agree to provide timely and continuous care for all my patients treated at UMMC Midtown Campus.

6. My appointment to the medical staff and continued clinical privileges remain contingent upon my continued demonstration of professional competency and cooperation, acceptable performance of all related responsibilities, as well as the other factors deemed relevant by UMMC Midtown Campus.

7. I have received and have had an opportunity to read a copy of the Medical Staff Bylaws and/or Allied Health Professionals policy plus the Rules and Regulations. I specifically agree to abide by the bylaws, policies, rules and regulations, and directives that are in force during the time I am appointed to the medical staff.

8. I also agree, as a condition or appointment, to adhere to the Corporate Compliance Policy of UMMC Midtown Campus and any laws, regulations, and standards of conduct applicable to my profession, participation in any federal health program, or activities of the UMMC Midtown Campus, and to report any known or suspected violation of the same by me or by any officer, director, employee, non-physician practitioner or other medical staff member to the Chief Executive Officer or the Compliance Officer.

9. I represent that all of the information provided in or attached to this application is accurate and complete. I understand and agree that any misrepresentations, misstatement, or omission from this application whether intentional or not, shall constitute cause for the immediate cessation of the processing of the application and no further processing shall occur. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may be deemed to constitute automatic relinquishment of my clinical privileges and medical staff appointment. In either situation, I am not entitled to any hearing or appeal rights that are contained in the Medical Staff Bylaws.

DATE: _____ _____

Signature of Practitioner

_____

Printed or Typed Name of Practitioner

RELEASE AND IMMUNITY

By applying for appointment and clinical privileges, I accept the following conditions and intend to be legally bound by them, regardless of whether or not I am granted appointment and/or clinical privileges. These conditions shall remain in effect for the duration of any term of appointment that I may be granted.

1. To the fullest extent permitted by law, I extend absolute immunity to and release from any and all liability, UMMC Midtown Campus, its medical staff, their authorized representatives and appropriate third parties for any matter relating to appointment, reappointment, clinical privileges, or the any qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken or received by UMMC Midtown Campus, the medical staff, their authorized representatives or appropriate third parties.

2. I authorize UMMC Midtown Campus, its medical staff, and their authorized representatives (i) to consult with any third party who may have information bearing on my professional qualification, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any matter reasonably having a bearing on my qualification for initial and continued appointment to the medical staff, and (ii) to obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of said third parties that my relevant to such questions. In addition, I specifically authorize these third parties to release information to UMMC Midtown Campus, its medical staff, and their authorized representatives upon request.

3. I also authorize UMMC Midtown Campus, its medical staff, and their authorized representatives to release such information to other hospitals, health care facilities, managed care entities, and their agents, who solicit such information for the purpose of evaluating my qualifications pursuant to a request for appointment and clinical privileges, participating provider status, or other credentialing matters.

DATE: _____ _____

Signature of Practitioner

_____

Printed or Typed Name of Practitioner