



Medical Staff Services
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8th Floor
Baltimore, MD 21201
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Checklist for University of Maryland Medical Center Rotation

This checklist outlines the documents required for credentialing as a rotator/visiting resident with the University of Maryland Medical Center. Rotators must complete the credentialing process prior to beginning any clinical activity. **Please submit all documents to your UMMC Contact in one package 60 days prior to rotation.** Any missing documentation will cause the packet to not be processed.

Forms Needed:

- Rotator Application
- Rotator Evaluation completed by the current training's program director

Documentation Needed:

- Current Curriculum Vitae
- Copy of primary source verification of medical school graduation or notarized copy of medical school diploma
- Proof of Immunizations** including PPD results from within the past year; If PPD positive, results from your most recent chest x-ray.
- Flu Vaccination Documentation** (required if rotating October 1 through March 31)
- Copy of ECFMG certificate (if international medical graduate)
- Copy of CPR certification(s) (i.e. ACLS, BLS, PALS)
- Letter verifying malpractice insurance coverage or insurance certificate
- NPI information: All UMMC rotators are required to have a NPI number. If the resident does not have an NPI, one must be obtained. An application can be completed online at <https://nppes.cms.hhs.gov>.

All documents should be mailed to your Rotation Coordinator at UMMC, NOT the medical staff office.

The UMMC Rotation Coordinator should then send complete packets to the MSO to rotation@umm.edu ONLY. Mailed or hand delivered packets will no longer be accepted. If the packet forwarded to the MSO does not include all documentation required above, the packet will not be processed. In addition, if the application(s) received is missing crucial information (including but not limited to: current training information, prior training information, dates of training, etc) it will not be processed. The rotator application is a legal document required to populate our database. This information then gets reported to various government agencies. Because of the number of rotators and amount of time it takes to process rotator packets, our office does not have the resources to follow up on missing information. Therefore, the application will not be processed with any missing information.

UMMC VISITING RESIDENT/FELLOW APPLICATION FORM

PART I: PERSONAL INFORMATION

Name (Last, First, Middle): _____ Degree (MD, DDS, RN, etc.): _____

Gender: Male Female Date of Birth: _____ Social Security Number: _____

E-mail: _____ Primary Contact Number: _____

Dates & /Department of Rotation: _____

National Provider Identifier (NPI) Number: _____

PART II: EDUCATION

1. Medical/Dental School

School Name _____ Dates Attended (MM/YY) From _____ To _____

If you are a foreign medical graduate, please complete the following:

ECFMG Number: _____ Date Passed: _____ Valid Until: _____

2. Current Residency/Fellowship Program

Institution Name _____

Program type (Specify):

Internship Residency Fellowship Specialty Training

Specialty _____ Dates Attended (MM/YY) From _____ to _____

3. Previous Residency/Fellowship Training Program

Institution Name _____

Program type (Specify):

Internship Residency Fellowship Specialty Training

Specialty _____ Dates Attended (MM/YY) From _____ to _____

PART III: PROFESSIONAL LIABILITY COVERAGE

Current Carrier:	Name:
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PART IV: ADDITIONAL QUESTIONS

Please attach an explanation for any **yes** answers.

	YES	NO
1. Have you ever faced disciplinary action or been placed on probation during training?	_____	_____
2. Have you ever resigned, been forced to resign, or been terminated from a training program?	_____	_____
3. Have you ever resigned, been forced to resign or been terminated from any employment?	_____	_____
4. Have you voluntarily or involuntarily relinquished or had any disciplinary action taken against any license or clinical privileges?	_____	_____
5. Do you have any physical/mental condition (including alcohol or drug dependence) that limits or Adversely affects your ability to participate fully in the care of your patients?	_____	_____
6. Are there any pending malpractice actions or findings of professional misconduct against you?	_____	_____
7. Have you pled guilty, nolo contendere, been convicted, received probation before judgment or other diversionary disposition of any criminal act?	_____	_____
8. Are there any criminal charges or convictions pending against you?	_____	_____

Failure to complete this application form in a timely manner, withholding of requested information, or providing false or misleading information shall, by itself, constitute a basis for the denial of participation in the requested rotation.

PART V: ATTESTATION (to be signed by all applicants)

By signing below, I, _____ attest that all information contained on this application is true to the best of my knowledge.

Signature of Applicant

Date



CONDITIONS OF APPOINTMENT AND CONSENT TO RELEASE OF INFORMATION

By applying for appointment or reappointment to the medical or affiliate staff of the University of Maryland Medical System Corporation d/b/a University of Maryland Medical Center, Maryland General Hospital d/b/a University of Maryland Medical Center Midtown Campus, James Lawrence Kernan Hospital, Inc., d/b/a University of Maryland Rehabilitation and Orthopaedics Institute, Baltimore Washington Medical Center, Inc., d/b/a University of Maryland Baltimore Washington Medical Center, Memorial Hospital of Easton, d/b/a University of Maryland Shore Medical Center at Easton, Dorchester General Hospital, d/b/a University of Maryland Shore Medical Center at Dorchester, Chester River Hospital Center, d/b/a University of Maryland Shore Medical Center at Chestertown, or Civista Medical Center, Inc. d/b/a University of Maryland Charles Regional Medical Center, University of Maryland St. Joseph Medical Center, LLC, d/b/a University of Maryland St. Joseph Medical Center, University of Maryland Upper Chesapeake Health System, Inc., d/b/a University of Maryland Upper Chesapeake and University of Maryland Harford Memorial Hospital, and any successor, or assignees of the foregoing, and any other designee of the University of Maryland Medical System Corporation, or of any facilities associated with the University of Maryland Medical System Corporation for medical staff membership, privileging or managed care credentialing purposes, (collectively and hereinafter “UMMS Affiliated Hospitals”), I understand and agree to the following:

1. All information submitted by me in this application is correct and complete to my best knowledge and belief. I fully understand that any significant mis-statements in or omissions from this application (which will be identified as such at the sole discretion of the UMMS Affiliate Hospital receiving the application form membership) constitute cause for denial of appointment or cause for summary dismissal from the medical staff of the UMMS Affiliated Hospital.
2. I agree that, if appointed, I will read and follow the Medical Staff Bylaws, any Rules and Regulations and all policies and procedures applicable to the medical staff, as they may be changed and updated from time to time.
3. I authorize the UMMS Affiliated Hospitals and its representatives, including members of the medical staff, to consult with other hospitals, including both UMMS Affiliated Hospitals and non-UMMS Affiliated Hospitals and their representatives and others, including malpractice carriers, in regard to this application. I understand that requests may be made of past or present medical affiliates, professional societies, licensing bodies, and other agencies regarding criminal history information. I release from liability all representatives of the UMMS Affiliated Hospital for their acts and services performed in good faith and without malice in evaluating the application. In addition, I release from liability those who may provide information to the UMMS Affiliated Hospital in good faith and without malice, and I consent to the release of any information including but limited to medical peer review material, which any other employer, insurance carrier, person, service, hospital, institution, professional society or licensing body may have which is related to the subject matters inquired of in this application, or to my qualification for medical staff membership.
4. I authorize, without reservation, any government agency contacted by the UMMS Affiliated Hospital and/or any other consumer reporting agency engaged by the UMMS Affiliated Hospital, to furnish information as to whether (a) I am excluded from participation in Medicare, Medicaid and/or any other Federal health care program or (b) if I am suspended, debarred or otherwise excluded from Federal Procurement and Nonprocurement Programs. This authorization includes, but is not limited to, obtaining and using information from the published List of Excluded Individuals/Entities (LEIE) maintained by the Office of the Inspector General (OIG) of the Dept of Health and Human Services (HHS) and the List of Parties Excluded from Federal Procurement and Nonprocurement Programs maintained by the Government Services Administration (GSA).
5. I consent to the release of information by the UMMS Affiliated Hospital and its representatives, including members of the medical staff and the Maryland Medicine Comprehensive Insurance Program, to other hospitals and their representatives, and to others*, including professional liability insurance carriers representing the Hospital, or persons affiliated with the UMMS Affiliated Hospital, provided that those to whom information is released have a legitimate interest in such information and provided that the information released pursuant to my consent may pertain to my appointment, reappointment, privilege delineation, disciplinary proceedings of any other hospital, health care institution, or agency which is related to patient care and professional conduct. I further understand that the information may relate to my professional qualifications, clinical competency, character, mental and emotional stability, ethics, and physical condition, ability to work compatibly with my peers and other UMMS Affiliated Hospital personnel, and any other matters that might directly or indirectly have an effect on my ability to render quality patient care.

*If I am a full-time or part-time member of the faculty of the University of Maryland School of Medicine who will provide billable services through a professional association under the Medical Service Plan, "others" includes third party payers with whom my professional association (and/or Faculty Physicians, Inc. (FPI) on behalf of my professional association) contracts, for the purpose of enabling these third party payers to accept me as a participating provider.

6. I agree to participate in and cooperate with the UMMS Affiliated Hospital's quality, utilization, and risk management programs. I agree to hold the UMMS Affiliated Hospital and representatives of the UMMS Hospital free from liability for actions performed in good faith as part of these programs.
7. I understand that, except for communications noted above in paragraphs 3 and 4, my application and all deliberations relating the consideration of my application shall be regarded and held as privileged and confidential documents by the UMMS Affiliated Hospital and medical staff to the fullest extent permitted by law. This also shall apply to the minutes of any hospital committee or other body which may consider my request for privileges.
8. I understand that I am obligated to report immediately to the UMMS Affiliated Hospital any occurrences, incidents, actions or other information relating in any way to questions in this application or responses I have provided to any such questions, if such occur following the submission of this application or its acceptance.
9. I agree to provide for continuous care for all patients under my care and to perform only that medical and surgical management for which I have requested and have been granted privileges, or which I am permitted by the Medical Staff Bylaws to perform in order to save the life of a patient in an emergency situation. I understand that if any application is rejected, I shall have no privileges whatsoever at the UMMS Affiliated Hospital or only those privileges eventually approved by the Governing Board of the UMMS Affiliated Hospital.
10. I understand that as a member of the Medical Staff, I am participating with the UMMS Affiliated Hospital in an organized health care arrangement as defined by the Privacy Regulations under HIPAA. I agree to comply with the UMMS Affiliated Hospital policies on protected health information and its Notice of Information Privacy Practices with regard to the UMMS Affiliated Hospital patients.
11. My credentials file is maintained by the Medical Staff Services Department and I authorize that office to share all documents contained in my credentialing file with all UMMS Affiliated Hospital entities with whom I am submitting an application for medical staff membership. I also authorize all UMMS Affiliated entities, all Medical Staffs and their authorized representatives to share peer review evaluations, data, and any other documentation concerning my practice, as necessary to process any applications that I have submitted for membership and/or privileges at any UMMS Affiliated Hospital.

Applicant's Signature: _____

Applicant's Name Printed: _____

Date: _____

Revised 4/2014