

Dear Doctor:

Thank you for your interest in North Kansas City Hospital. Our Hospital has adopted the following membership criteria to assist our Medical Staff achieve a high standard of patient care. Once you mail your completed Medical Staff Membership Application, we will review your credentials thoroughly before making a recommendation to the governing body regarding your appointment to the Medical Staff.

An applicant for Medical Staff membership must:

- Be an MD, DO, DDS, or DPM
- Be board certified or in the process of becoming board certified (within 6 years of completion of approved residency program)
- Hold a current state license in the state of Missouri
- Have a valid federal DEA Controlled Substances Registration Certificate registered in the State of Missouri, a Bureau of Narcotics and Dangerous Drugs Missouri Controlled Substances Registration Certificate
- Maintain professional liability insurance in the amount that the state of Missouri requires (\$500,000 per occurrence and \$1,000,000 in aggregate per year)
- Have or plan to establish an office within 30 minutes of the hospital to allow for continuous patient care

We use a pre-application process to determine whether prospective applicants meet our basic criteria for Medical Staff membership, and to determine whether we can accommodate prospective applicants. Please complete the enclosed pre-application form and return it along with a copy of your curriculum vitae in the enclosed envelope.

We will review your pre-application and the accompanying documentation. If you meet our general membership criteria, we will provide you with an Application for Membership to the Medical Staff, the appropriate delineation of clinical privileges request forms, and an invoice for a non-refundable application processing fee of Two Hundred Fifty Dollars (\$250.00) payable to North Kansas City Hospital.

Please do not hesitate to contact Medical Staff Services at 816-691-2050 if you need assistance.

PRE-APPLICATION FORM

(Please note - this is **NOT** an application for Medical Staff Membership)

Name In Full: _____

Office Address: _____

Office Telephone: _____

Residence Address: _____

Residence Telephone: _____ Check Here If Silent ()

Please Note: Should you be appointed to North Kansas City Hospital’s Medical Staff, you will be assigned the category of “Active-Initial Appointment” for a period of at least one year. The following is an excerpt from North Kansas City Hospital’s Medical Staff Bylaws regarding the Medical Staff Category for initial appointment:

“The Active-Initial Appointment Medical Staff category shall consist of physicians and dentists who are being considered for advancement to membership on the Active Staff, Courtesy Staff or Consulting Staff after membership on the Active-Initial Appointment Staff for a minimum of (1) year.”

Please indicate the clinical specialty in which you desire appointment and clinical privileges:

SPECIALTY:

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergy & Immunology | <input type="checkbox"/> Hospice & Palliative Medicine | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Perinatology |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Periodontics |
| <input type="checkbox"/> Cardiothoracic Surgery | <input type="checkbox"/> Internal Medicine/Pediatrics | <input type="checkbox"/> Physical Medicine & Rehab |
| <input type="checkbox"/> Colon & Rectal Surgery | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Dentistry | <input type="checkbox"/> Neurology | <input type="checkbox"/> Podiatry |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Obstetrics & Gynecology | <input type="checkbox"/> Pulmonary Medicine |
| <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Oral & Maxillofacial Surgery | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Orthopedic Surgery | <input type="checkbox"/> Teleradiology |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Therapeutic Radiology |
| <input type="checkbox"/> Gynecology | <input type="checkbox"/> Pain Management | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Hematology/Oncology | <input type="checkbox"/> Pathology | <input type="checkbox"/> Vascular Surgery |

Other: _____

Please describe your medical education / training:

Medical School: _____
Date of Graduation: _____

Internship: _____
(Specialty) _____
Dates: From _____ To _____

Residency: _____
(Specialty) _____
Dates: From _____ To _____

Fellowship: _____
(Specialty) _____
Dates: From _____ To _____

Board Certification

Each applicant for membership to the Medical Staff shall have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in a specialty in which the applicant seeks clinical privileges, or a dental surgery training program accredited by the Commission on Dental Education of the American Dental Association, or a podiatric surgical residency program accredited by the Council on Podiatric Education of the American Podiatry Association.

Each applicant for membership to the Medical Staff shall become certified within six years of completion of residency training by the appropriate specialty board of the American Board of Medical Specialties, The American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, as applicable, and shall maintain such board certification as a condition of remaining a member of the Medical Staff.

Are you Board Certified? ___ YES ___ NO

Where do you currently have medical staff appointment and clinical privileges? Where are you in the process of applying for such appointment?

Facility

Specialty

Category or Status of Appointment

Do you plan to establish, or have you established an office near the hospital?

Where: _____

When will you open an office at that location? _____

Do you plan to become an associate of one the physicians on our staff? _____ YES _____ NO

If so, which practice? _____ When? _____

Please return this form with copies of the following documents:

- a) Current license to practice
- b) Missouri BNDD Registration Certificate
- c) DEA Registration Certificate (you will need a DEA registered in Missouri for appointment)
- d) Proof of malpractice liability insurance coverage or eligibility, which indicates the effective date and amount. (Please note a minimum of \$500,000 coverage is required for each occurrence.)
- e) Curriculum Vitae (CV)

I certify that I meet the basic threshold criteria for membership on the Medical Staff of North Kansas City Hospital and request an application for appointment to the Medical Staff. I understand this is not an application for membership on the Medical Staff and I may not receive an application if it appears this pre-application questionnaire form reveals that I do not meet the threshold requirements.

Signature

Date
