

Peoria Medical Society

Request for Additional Information



Please print or type.

All blanks must be filled in or marked N/A (Non-Applicable).

When do you need to obtain Hospital Staff Privileges? _____

Please check (x) the appropriate box(es). **ONLY** apply to those hospitals/institutions where you will be practicing.

You are seeking appointment to:

- Center for Health Ambulatory Surgery Center, LLC
- Graham Hospital - Canton, IL
- Methodist Medical Center
- Proctor Hospital
- Fayette Companies
(Human Service Center/White Oaks Companies)

- OSF Saint Francis Medical Center
- Perry Memorial Hospital
- Proctor First Care
/Proctor Health Systems, Inc.
- Peoria Day Surgery Center
- Peoria Ambulatory Surgery Center
- Renal Intervention Center

You are requesting privileges in the following departments _____

Is your practice limited to a specialty or sub-specialty? Yes No

If yes, please indicate: _____

Personal Identification Data

Name _____
Maiden Name _____
Local Peoria Home Address _____
City/State/ZIP _____
Local Peoria Home Phone # _____

Alternate/Backup

Physician Coverage Information

Physician's Name(s) _____
Pager # _____ Phone # _____
Group Name _____
Address _____
City _____ State _____ ZIP _____

Please Enclose the Following

1. List and copy of CME's obtained in the last year.
2. Photo(s) for each institution you are seeking privileges.
3. Photo for the Peoria Medical Society file.

OPTIONAL INFORMATION:

Marital Status Single Married Widowed Divorced

Name of Spouse _____

Office Email Address _____

Home Email Address _____

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ADVERSE OR OTHER ACTIONS

Submit with all applications. Please answer the following questions to the best of your knowledge with a "yes" or "no". If you answer "yes" to questions(s) 1 or 2, please provide an explanation below or on an additional sheet of paper.

- 1.) Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgical center membership for any reason? (If yes, please explain on a separate page)

_____ Yes _____ No

- 2.) Do you have any restrictive endorsements on your malpractice insurance coverage?

(If yes, please explain and/or list exclusions on a separate page)

_____ Yes _____ No

- 3.) Are the majority of the CME credits that you have obtained as required by the Medical Practice Act to maintain your Illinois State Medical License directly related to the clinical privileges you are requesting?

(If "no", please provide an explanation on a separate page.)

_____ Yes _____ No

Note: Proof of attendance and program content for CME credits must be submitted upon request. (Not applicable for Residents, Fellows, Allied Health Professionals or those who just obtained their license.)

TB Testing

- 4.) Please provide proof of a current (within the past year) Two- Step TB test.

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- 5.) Please be advised that the local hospitals require completion of a Kroll background check as part of the credentialing process. This includes but is not limited to a county, state, and federal criminal search, a driving record, and a Social Security trace.

Please answer all questions throughout the application fully and truthfully. The questions on pages 19-21 are clear and concise, such as have you **ever been charged with, convicted of, or are there any currently pending** actions. If you are unsure of how to answer a specific question, please err on the side of offering more information rather than less. Any misrepresentation or omission from the application, whether intentional or not, may be cause for immediate cessation of the appointment process. Forms A through F provide the applicant the opportunity to explain specific details and disposition of each occurrence, incident, or circumstance. Specific questions should be addressed to the Peoria Medical Society or the Medical Staff Office of participating facilities.