

# 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 wish to obtain Hospital Staff Privileges by?

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

You are seeking appointment to:

- |   |   |
|---|---|
| <input type="checkbox"/> Center for Health Ambulatory Surgery Center, LLC | <input type="checkbox"/> OSF Saint Francis Medical Center               |
| <input type="checkbox"/> Central Illinois Endoscopy Center                | <input type="checkbox"/> OSF Saint James - John W. Albrecht Medical Ctr |
| <input type="checkbox"/> Graham Health System - Canton, IL                | <input type="checkbox"/> Proctor First Care                             |
| <input type="checkbox"/> Methodist Medical Center                         | <input type="checkbox"/> /Proctor Health Systems, Inc.                  |
| <input type="checkbox"/> Proctor Hospital                                 | <input type="checkbox"/> Peoria Day Surgery Center                      |
| <input type="checkbox"/> Human Service Center                             | <input type="checkbox"/> Peoria Ambulatory Surgery 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(s) \_\_\_\_\_  
Local Home Address \_\_\_\_\_  
City/State/ZIP \_\_\_\_\_  
Local Home Phone # \_\_\_\_\_  
Home Email Address \_\_\_\_\_

### 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 \_\_\_\_\_

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## Request for Additional Information Continued

### 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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## Request for Additional Information Continued

- 5.) Please be advised that the local hospitals require completion of a 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.