Application for Medical Staff Membership

Name of Applicant: ______________________________ Date of Application: ____________________
(Last/First/Middle) Specialization: ____________________

Personal Data

Office(s)

Street address ______________________________

City ______________ State ______ Zip Code ________ E-mail ______________

Telephone ______________ Fax ______________

Street address ______________________________

City ______________ State ______ Zip Code ________ E-mail ______________

Telephone ______________ Fax ______________

List Trinity Health hospital(s) at which you are on staff (hospital name, city, state):

____

____

Home

Street address ______________________________

City ______________ State ______ Zip Code ________ E-mail ______________

Telephone ______________ Fax ______________

Additional Information

Sex ☐ Female ☐ Male Social Security Number ______________

Date of Birth ______________ Place of Birth ______________

Citizenship ______________ Visa Status ______________

Spouse's name (if applicable) ______________________

Formal Education

Premedical

Name of Institution ______________________

City, State, Country of Institution ______________________

Dates ______________________

Degree ______________________

Medical

Name of Institution ______________ Name of Institution ______________

City, State, Country ______________ City, State, Country ______________

Dates ______________ Dates ______________

Degree ______________ Degree ______________

(continued)

Formal Education (*continued)*

Residencies

Name of Hospital ______	Name of Hospital ______
Address ______	Address ______
City, State, Country ______	City, State, Country ______
Dates ______	Dates ______
Degree ______	Degree ______

Fellowships	**Teaching Appointments**
Name of Hospital ______	Name of Hospital ______
Address ______	Address ______
City, State, Country ______	City, State, Country ______
Dates ______	Dates ______
Degree ______	Degree ______

How many hours per week can you contribute to teaching: ______

Please list your recent publications and referee journals (Use separate sheet if necessary):

Licensure/Board Certification

Licensure

State Medical License No. ______ Date Issued ______ Expiration Date ______

Controlled Substance Number ______ Expiration Date ______

ECFMG License Number ______

Board Certification

American Board ______ Date ______

Subspecialty Board ______ Date ______

Additional Certifications ______ Date ______

Membership Status Requested/Clinical Privileges Requested

All initial appointments are for a provisional period of twelve (12) months.

Status: ☐ Provisional Active ☐ Courtesy ☐ Consulting

Department: ______ Subspecialty: ______

List specific privileges requested (Use separate sheet if appropriate).

(continued)

Memberships on Medical Staffs (Include past and present)

Name of Hospital ____________________ **Name of Hospital** ____________________
Address ____________________ Address ____________________
City, State, Country ____________________ City, State, Country ____________________
Dates ____________________ Dates ____________________
Staff Status ____________________ Staff Status ____________________
Name of Hospital ____________________ **Name of Hospital** ____________________
Address ____________________ Address ____________________
City, State, Country ____________________ City, State, Country ____________________
Dates ____________________ Dates ____________________
Staff Status ____________________ Staff Status ____________________

Memberships or Affiliations in Professional Societies

Name of Society ____________________ Name of Society ____________________
Name of Society ____________________ Name of Society ____________________
Name of Society ____________________ Name of Society ____________________

References

Name ____________________ Title ____________________
Address ____________________
Name ____________________ Title ____________________
Address ____________________
Name ____________________ Title ____________________
Address ____________________
Name ____________________ Title ____________________
Address ____________________

Additional Information

1. Have any disciplinary proceedings regarding your license to practice medicine ever been initiated against you?
   ☐ No ☐ Yes
2. Has your license to practice medicine in any jurisdition ever been suspended or revoked?
   ☐ No ☐ Yes
3. Have any disciplinary proceedings regarding your hospital privileges ever been instituted against you?
   ☐ No ☐ Yes

(continued)

(continued)

Additional Information *(continued)*

4. Have your privileges at any hospital ever been denied, suspended, revoked or not renewed?
   ☐ No ☐ Yes
5. Have any malpractice suits been filed against you?
   ☐ No ☐ Yes If yes, please give brief description and outcome (on reverse side)
6. Do you have any physical or emotional problems that could impair your ability to practice quality patient care, especially in an unfamiliar overseas environment? ☐ No ☐ Yes
   If your answer is Yes, please explain: ______________________________

Languages

Please list languages you speak other than English

Language	Read: Yes/No	Write: Yes/No	Speak Fluently: Y/N	Speak to Some Degree: Y/N

International Experience

Have you ever traveled overseas: ☐ Yes ☐ No

Country/Countries Traveled In and Dates of Travel

Do you have current affiliations/relationships/contacts with physicians or medical facilities overseas?

☐ No ☐ Yes If yes, please explain.

Previous International Experience

Have you ever worked overseas: ☐ Yes ☐ No

Country Served In	Dates of Service	Sponsoring Agency	Type of Work

Desired International Service

Please list preferred countries where you would like to serve: ☐ No preference

Please list any countries in which you **do not** wish to serve:

Please check the maximum length of time you would consider for overseas service:

☐ 1 week ☐ 2 weeks ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other ______________________

Earliest date available for assignments: ____

Do you possess a valid passport: ☐ Yes ☐ No

Are you interested in participating in (check all applicable)...

☐ Provision of direct care (medical missions)

☐ Consulting

☐ Medical Advisory Panel

☐ International Patient Services Program (referral)

☐ Other (please specify) ____

Compensation

What type of financial support would you require for an international assignment (check more than one if appropriate):*

☐ My full salary and full expenses

☐ Expenses only, no salary

☐ Airfare only, no salary or other expenses

☐ Living expenses only, no airfare or salary

☐ I would serve as a full volunteer at my own expense

☐ Other: ______________________________________

*Please note, Trinity Health International tries to obtain full financial support for staff whenever possible.

I understand that any deliberate falsification of information provided in response to this application form will be just cause for dismissal from Trinity Health International programs. By submitting this signed application, I acknowledge that Trinity Health International may conduct a background search, National Database of Practitioners Inquiry and/or reference checks prior to confirming employment or contracting of my services.

______________________________ ______________________

Applicant's Signature Date

General Information/Instructions:
Trinity Health employees, retirees, foreign service club members and other affiliates (i.e., physicians) are eligible for Trinity Health International assignments. Please return this completed form and a copy of your resume to: Trinity Health International, 34605 Twelve Mile Road, Farmington Hills, MI, 48331-3293.