CalvertHealth Medical Center
100 Hospital Road
Prince Frederick, MD 20678

410.535.4000
301.855.1012
410.535.5630 TDD

CalvertHealthMedicine.org

ADDENDUM TO MARYLAND HOSPITAL CREDENTIALING APPLICATION

Applicant: _____

Staff Category: [ ] Active [ ] Active without clinical privileges [ ] Consulting [ ] Allied Health [ ] Telemedicine

Spouse's Name: _____ [ ] N/A

Your E-mail Address: _____

Practicing with whom? _____ [ ] Solo

Anticipated start date: _____

Direct or Indirect Interest:

Do you or a member of your immediate family have a direct or indirect ownership interest, significant financial interest or serve as a member on the board of directors or trustees, or otherwise have a leadership position or have significant control regarding any of the following:

	Yes	No
Hospital		
Clinical Laboratory		
Diagnostic or Testing Center		
Surgery Center		
Pharmaceutical Company		
Medical Device Company		
Medical Equipment/Supplies		
Ancillary Health Services (Home Health, Hospice; Physical, Occupational or Speech Therapy; Durable Medical Equipment; Infusion Therapy; etc.)		
Other entity providing services in competition with CalvertHealth System, CalvertHealth Medical Center or subsidiaries		

If so, complete the following for each entity:

Name of Organization: _____

Address of Organization: _____

Type and Size of Organization: _____

Nature of Business Interest (whether ownership and/or compensation and if personal or immediate family member: _____

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Professional Back-up Coverage:
List the name(s) and phone number(s) of the physicians(s) with appropriate clinical skills with whom you have entered into an arrangement that ensures 24-hour, 7-day a week back-up coverage for your patients when you are not available. **Must** be a current member of the Medical Staff of CalvertHealth Medical Center.

Name:_____

Information Systems Access: Healthcare Provider Password Agreement
I, the undersigned, acknowledge the request of information system USER ID(s) and PASSWORD(s) which will allow me to gain access to Calvert Health System's information systems. I understand that:

- This user PASSWORD is the legal equivalent of my signature; I will not disclose this information to anyone.
- I will not attempt to learn the PASSWORD of any other person.
- I will not attempt to access information on Calvert Health System's information systems using a PASSWORD other than my own.
- I will not leave a computer unattended while I am still actively logged on to the system.
- I will not attempt to access unauthorized information on Calvert Health System's information systems.
- I will contact the Information Services Department (410-535-4000, x-4357) immediately if I have reason to believe that the confidentiality of my user PASSWORD has been compromised. An Information Services team member will reassign a new PASSWORD to me or will notify the administering department to do so.
- As a healthcare provider or employee of a healthcare provider, I will, at all times observe and protect the patient's right to confidentiality of their medical record information in accordance with Calvert Health System confidentiality Policies, Medical Staff bylaws, professional ethics, the laws of the State of Maryland, and the privacy and security regulations of HIPAA.
- I understand that I will be subject to immediate suspension or revocation of my PASSWORD if I or my designated proxy violates any of the agreed upon statements.

I affirm that in conjunction with the granting of privileges, I have read and will abide by the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Hospital and Medical Staff policies.

_____

Signature of Applicant Date

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Malpractice Claim/Lawsuit History

NOTE: FAILURE TO DISCLOSE INFORMATION MAY RESULT IN REJECTION OF YOUR APPLICATION IN ACCORDANCE WITH THE MEDICAL STAFF BYLAWS

Please copy this addendum form for each additional claim/lawsuit

Name of Claimant: _____

Date of Incident: _____

Date Lawsuit/Claim Filed: _____

Full Case Caption
Case Number: _____

Description: _____

_____

_____

_____

Status of the Case (with reference to you, specifically):

_____ Pending
_____ Closed Without Payment
_____ Pre-Trial Settlement ($_____)
_____ Verdict for Defendant
_____ Verdict for Plaintiff ($_____)
_____ Other (_____)

What was/is your status:

_____ Sole Defendant
_____ Co-Defendant (with _____)
_____ Other: _____

Name and Policy # of
Insurance Carrier: _____

❒ **No history of malpractice claims**

Signature: _____

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Provider Contact Information

This form will be used by the hospital operators.

Name: **Group Name:** **Office hours:**		**Rate preferred order of contact** ***For example:*** **1st H** **2nd O** **3rd C**
During Office hours	**H- Home phone #_____** **O-Office #_____** **C- Cell phone #_____** **OT- email** **_____**	**1st ___** **2nd ___** **3rd ___** **4th ___**
After Office hours	**H- Home phone #_____** **O-Office #_____** **C- Cell phone #_____** **OT- Email** **_____**	**1st ___** **2nd ___** **3rd ___** **4th ___**
Home Address	**Street_____** **City/State/Zip_____** **Phone:_____**	
Office	**Street_____** **City/State/Zip_____** **Phone:_____ Fax: _____**	