Calvert Memorial Hospital

Tradition. Quality. Progress.

NAME:_____ **DATE:**_____

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: _____

PRACTITIONER ACKNOWLEDGEMENT AND AUTHORIZATION FOR RELEASE

Calvert Memorial Hospital Providers
OR
Calvert Physician Associates / (CPA) Providers

My application for appointment or reappointment to the Calvert Memorial Hospital Medical Staff is contingent upon my obligation of the following:

1. I authorize Hospital representatives, including Calvert Physician Associates (CPA) representatives, **if applicable**, to consult with others associated with the applicant and/or who may have information bearing on the applicant's competence and qualifications.

2. I agree to abide by the terms of the Bylaws, Rules, Regulations, Policies and Procedures of the Hospital and Medical Staff in all matters relating to the consideration of the application and the exercise of Medical Staff Membership and clinical privileges.

3. I release from any and all liability all Hospital and CPA representatives for their actions performed in good faith and without malice; in connection with providing, obtaining or reviewing information and evaluating or making recommendations concerning the applicant and the applicant's credentials. The term "hospital representatives" as used in these bylaws include members of the Board of Trustees, all officers, employees, and agents of the Hospital, all members of the Medical Staff, and all officers of the Medical Staff, its departments and committees, having responsibility for collecting or evaluating information concerning my credentials or making recommendations or acting on any application for Medical Staff membership or clinical privileges.

4. I release from liability all individuals and organizations who provide, in good faith and without malice, information to Hospital representatives, including otherwise privileged or confidential information, relating to my ability, background, professional ethics, character, physical and mental health, emotional stability, and other matters relating to my qualifications for staff appointment and clinical privileges.

5. I authorize and consent to Hospital and CPA representatives providing other hospitals, medical associations, licensing boards and other organizations concerned with provider performance and the quality, appropriateness, and efficiency of patient care with any information related to such matters which the Hospital may have concerning the applicant, and releases the Hospital and its representatives from all liability for providing such information.

6. I authorize Calvert Memorial Hospital and CPA to release my National Provider Identifier (NPI) Number to individuals and organizations requiring the number for billing purposes.

7. If deemed necessary for required peer review, I agree to provide specific patient data related to the treatment of my patients treated or admitted to CMH for care.

8. I acknowledge that the granting of Medical Staff membership and clinical privileges shall not signify employment by Calvert Memorial Hospital for any purpose and I shall at all times be an independent practitioner unless a separate employment relationship is established by contract with the hospital, above and beyond having medical staff membership and clinical privileges.

9. I agree to respond to all requests for information, explanation, or other, from any regulatory agency of county, state or federal government; the PRO, HMOs, PPOs, indemnity insurance and other third party payers promptly and in detail.

Please add Passport size photo quality picture here.

_____
PRINTED NAME

_____ _____
SIGNATURE DATE