

**REQUEST FOR APPLICATION**

September 21, 2009

Dear Dr. Doctor:

Thank you for your interest in Mercy Medical Center Redding, St. Elizabeth Community Hospital, and/or Mercy Medical Center Mt. Shasta and our communities. Our Board of Directors, after consultation with the Medical Staffs, has adopted the following general membership standards. These general standards have been adopted to assist CHW–North State Region in achieving an appropriately high standard of patient care. Please be aware that these are baseline standards. Our Medical Staff, upon review of a completed application, will conduct a further review of your credentials prior to making a recommendation to our Board.

1. Board certified by one of the ABMS (American Board of Medical Specialty) or one of the AOA (American Osteopathic Association) Specialty Boards is preferred. At a minimum, the applicant must have satisfactorily completed an ACGME (Accreditation Counsel of Graduate Medical Education) or AOA approved residency, or who can demonstrate clinical experience that is equivalent to the approved residency.

***MMCR and SECH Only:*** Exceptions may be made by the Medical Executive Committee for physicians who wish to surgical assist only.

2. Have actively practiced at least 18 months out of the last 24 months (residency or private practice).

***\*(See page 2 of this letter)***

3. Have actively practiced at a hospital at least two of the past five years.

***\*(See page 2 of this letter)***

4. Meet the following requirements concerning response:

- (a) ***MMCR Only:*** Have established or plan to establish an office and residence within 35 miles of the hospital unless you are joining a group and at least one member of the group lives within that distance, and they will cover for you in an emergency. This applies to Active and Provisional/Active Staff only.
- (b) ***SECH Only:*** All members must be able to respond to their patients in the Hospital within 30 minutes, or have an alternative care provider who can respond in the event of an emergency.
- (c) ***MMCMS Only:*** Have offices or residences that, in the opinion of the medical executive committee, are located closely enough to the hospital to provide continuity of quality care and/or provide proof of back-up coverage.

5. Currently licensed to practice medicine in the United States and maintain a Federal DEA number.
  
6. Malpractice Insurance Requirements:
  - (a) **MMCR Only:** You will also be required to maintain professional liability insurance with a company licensed to sell insurance in the State of California and either admitted\*\*(see below) by the Insurance Commission of the State of California, covered by a California University or CHW Trust, or which has at least an A- Rating with an A.M. Best company. Minimum amount will be not less than \$1,000,000 per occurrence, \$3,000,000 aggregate claims per year.
  
  - (b) **SECH Only:** You will also be required to maintain professional liability insurance with a company licensed by the Insurance Commissioner of the State of California. Minimum amount will be not less than \$1,000,000 per occurrence, \$3,000,000 aggregate claims per year.
  
  - (c) **MMCMS Only:** Physicians will be required to maintain professional liability insurance with a minimum amount of not less than \$1,000,000 per occurrence, \$3,000,000 aggregate claims per year. Dentists will be required to maintain professional liability insurance with a minimum amount of not less than \$500,000 per occurrence, \$1,500,000 aggregate claims per year.

Please complete the enclosed form and return it to me at your earliest convenience. We will review and verify the information and will contact you within two weeks. At that time, and providing you meet our general membership standards, you may be provided with an application for membership and an invoice for a non-refundable \$300.00 application fee.

If I can be of any assistance to you, please do not hesitate to contact me.

Sincerely,

Jenny L. Pierce, CPCS  
Credentialing Coordinator  
Medical Staff Services

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***\*This requirement may be waived by the Medical Staff Executive Committee if the practitioner has maintained continuing education during his/her absence, which is pertinent to the privileges requested.***

***\*\*"Admitted" by the Insurance Commission of the State of California means a company that participates in the California Insurance Guarantee Association (CIGA) which is an insurance company that is licensed in California and pays a tax which offers coverage for certain insolvencies.***

**APPLICATION REQUEST FORM**

I request an application form for the staff of:

- Mercy Medical Center Redding**
- St. Elizabeth Community Hospital**
- Mercy Medical Center Mt. Shasta**

**Please Note:** Privileges in the following specialties are covered under Exclusive Contracts. Therefore, privileges in these areas will be granted only to practitioners affiliated with the individual/group holding the Exclusive Contracts:

Mercy Medical Center Redding:

Cardiovascular Services  
Emergency Services  
Pathology  
Radiation Oncology  
Radiology/Diagnostic Nuclear Medicine

St. Elizabeth Community Hospital:

Emergency Services  
Pathology  
Radiology

Mercy Medical Center Mt. Shasta

Emergency Services  
Pathology  
Radiation Oncology  
Radiology

NAME: \_\_\_\_\_

Date of Birth \_\_\_\_\_

Specialty: \_\_\_\_\_

Sub-specialty(ies): \_\_\_\_\_

To be affiliated with: \_\_\_\_\_

Solo practice

Current Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Current Telephone Number: \_\_\_\_\_

Please provide the following information:

A. Medical/Professional school attended: \_\_\_\_\_ Date Graduated \_\_\_\_\_

B. ACGME Approved Residency Program(s) \_\_\_\_\_ Date Graduated \_\_\_\_\_

\_\_\_\_\_ Date Graduated \_\_\_\_\_

\_\_\_\_\_ Date Graduated \_\_\_\_\_

C. In chronological order, list all hospitals in which you have held clinical privileges during the past five years (if applicable):

<u>HOSPITAL</u>	<u>COMPLETE ADDRESS</u>	<u>FROM</u>	<u>TO</u>
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1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

***Request for Application***

- D. Please **attach a copy** of your certification from your Specialty Board **and/or** a certificate of completion of your residency program.
- E. Please **attach copies** of your current license and your DEA registration.
- F. \_\_\_\_\_ I have malpractice insurance (in the required amounts) and meeting the requirements outlined in the preapplication letter or such insurance is pending. (**attach copy of verification of current insurance coverage**).
- G. Check One:
- \_\_\_\_\_ I plan to establish an office per stated requirements.
- \_\_\_\_\_ I plan to join a group where at least one-half of the group meets stated requirements, and they will cover for me in an emergency.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

***Please submit Preapplication and information to  
North State Service Area  
% Medical Staff Services  
2175 Rosaline Ave.  
P. O. Box 496009  
Redding, CA 96049-6009***