The Medical Center *of* Plano

Request for Application for Medical Staff

Name:_____ CONTACT #_____

Mailing Address:_____

NPI #_____ SSN# _____ DOB_____

Medical/Surgical Specialty:_____

Will you request clinical privileges?_____ or Affiliate Staff (with NO privileges)?_____

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QUALIFICATIONS:

Are you currently certified by your Specialty Board?_____

If not certified, have you completed Residency Training in your Specialty?_____

What is the date you completed training in your specialty? _____

It is a requirement that all new applicants achieve board certification **within 5 years** following completion of training and maintain certification.

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PRACTICE:

Will you be establishing a new solo practice; or joining an existing practice/group?

☐ SOLO PRACTICE ☐ JOINING: _____

It is REQUIRED that you have BACKUP* with a physician (in your specialty) who is also a member of the medical staff at Medical Center of Plano. Indicate which physician(s) will provide **EMERGENCY BACKUP** for you:_____

To what extent do you anticipate using the facilities at Medical Center of Plano?

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EMERGENCY ROOM CALL:

NEW members of the Medical Staff **MUST participate in the ER call** for a minimum of ONE YEAR*. Upon completion of that year, depending on elective activity at Medical Center of Plano, you may be appointed to the COURTESY STAFF (if you have fewer than 24 elective admissions, consultations, or surgical procedures). If activity exceeds 24, you will be appointed to the ACTIVE STAFF and required to continue serving on the ER call schedule. Do you **accept** this responsibility if appointed to our Staff?_____

*No ER Call or Backup Required for **Affiliate Staff** members (no clinical privileges). Internal Medicine & Family Medicine applicants (with privileges): You will not be required to take ER "Call"; but will be placed on ER Referral List (for office followup care for patients seen in ER or patients admitted by hospitalists)

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I understand I will be receiving a Request for Consideration from the HCA Central Processing Center. I understand the above information will determine my eligibility and that this questionnaire is not an application. I understand that if it is determined that I am not eligible to receive an application, I have no rights to appeal the decision.

Physician's Signature: _____

THERE IS A NON-REFUNDABLE $300.00 PROCESSING FEE WHICH FUNDS MEDICAL STAFF LEADERSHIP. YOUR REQUEST FOR CONSIDERATION WILL BE SENT AFTER THIS FEE HAS BEEN RECEIVED. PLEASE SEND THIS FORM AND FEE TO: Medical Staff Office, Medical Center of Plano, 3901 W. 15th St., Plano, TX 75075.