Medical Staff Application Eligibility Survey

The Guadalupe Regional Medical Center (GRMC) Medical Staff is committed to providing top quality medical care to our community through competent and skilled providers, through a well woven network of primary care and specialty physicians, through seamless continuity of care, and as reflected in excellent outcomes of care and patient and family satisfaction. GRMC has become a five star, commended health care facility as a direct result of commitment and careful planning.

As such, we consider GRMC Medical Staff membership a privilege, and we require that any physician or independent practitioner interested in membership first complete the attached pre-application survey.

Please answer the following questions fully and truthfully. If you are unwilling to answer any question or are found to have provided an untruthful or incomplete answer, Guadalupe Regional Medical Center (GRMC) Credentialing Committee reserves the right to refuse to allow you to apply for medical staff privileges or for renewal of medical staff privileges. **Failure to allow a physician to apply for medical staff membership due to the failure to meet eligibility criteria is not an action that is reportable to the National Practitioner Data Bank. Failure to approve during the credentialing process due to quality concerns may be reportable.**

Applicant’s Printed Full Name: ____________________________________________
Please review the following categories of staff membership as defined by the Medical Staff Bylaws and check the category for which you would be requesting privileges:

____ Active: The Active Medical Staff shall consist of physicians and oral surgeons who are located within a reasonable distance and/or travel time to provide continuous care to his/her patients. “Reasonable” shall be determined as part of the credentialing process based on the physician’s specialty and scope of care at the hospital. Active staff members may admit patients and/or utilize the various diagnostic and therapeutic services. Their responsibilities shall include serving on committees to which they may be appointed and participating in the emergency room roster as needed. During initial appointment, an Active Staff member will be evaluated under Focused Practice Performance Evaluation (FPPE) and will continue to be monitored and held to staff standards (OPPE) under ongoing practice review for the duration of their tenure. Members of the Active Medical Staff shall be eligible to vote, hold office, and transact all business of the Active Staff.

____ Community Based: These physicians, typically primary care physicians, are based exclusively in a local office practice and have subrogated their admitting privileges through an established arrangement with an Active Staff physician(s). As such, they are exempted from standard OPPE/FPPE monitoring processes related to inpatient hospital care. These physicians have a responsibility to participate in unassigned patient call for the purpose of ER and hospitalist discharge follow-up care, and are eligible to vote.

____ Consultant: The Consulting Medical Staff shall consist of those physicians of recognized ability who meet the qualifications for Medical Staff membership. Consulting Staff members shall not be eligible to admit patients, but may consult on and treat patients in the hospital only at the request of an Active Staff member. Consultants may evaluate or treat inpatients under the primary care of that Active Staff member and may order outpatient diagnostic or therapeutic services. Consulting Medical Staff members may not vote or hold office. Held to applicable FPPE and OPPE standards.

____ Cross Coverage: This Staff category is currently not defined in the Bylaws, but may soon be added as a subset category of Consultant. A cross covering physician is typically one who is in a large specialty group (i.e., Nephrology, Cardiology, Oncology) and who covers for one main provider who is established in Seguin, or who occasionally cross cover for a Seguin based specialist from New Braunfels or San Marcos (i.e., ENT). Held to applicable FPPE and OPPE standards.

____ Courtesy: The Courtesy Staff shall consist of those members of the dental profession, the podiatric profession, and of the medical profession who are eligible as herein provided for Medical Staff membership and who wish to attend patients in the hospital after consultation with a member of the Active Staff. They shall be appointed in the same manner as other members of the Medical Staff, but they shall not be eligible to vote or hold office. Held to applicable FPPE and OPPE standards.
The following is a list of specialty privileges available at GRMC. Please check all in which you would seek privileges at GRMC.

- Anesthesia
- Internal Medicine
- Physical Medicine
- Cardiology
- Interventional Cardiology
- Podiatry
- Physical Medicine
- Maternal Fetal Monitoring
- Pulmonology
- Radiology (including interventional)
- Family Medicine
- OB-GYN
- Urology
- Emergency Medicine
- Nephrology
- Vascular Surgery
- Dentistry
- Maternal Fetal Monitoring
- Pulmonology
- Radiology (including interventional)
- General Surgery
- Pathology
- Wound Care
- Gastroenterology
- Otolaryngology
- Hematology/Oncology
- Pediatrics
- Other:_____________
- Sedation: “sedation” by any means describes a state, which allows patients to tolerate unpleasant procedures while maintaining adequate cardiopulmonary functions and the ability to respond purposefully to verbal commands and/or tactile stimulation.

Are you board certified in the above specialty(ies)? Yes _____ No_____

Please list the related ABMS or AOA approved board: __________________________________________

If not, are you eligible as per your specialty board definitions? Yes _____ No _____

When did you complete residency? _____________

Board certification or current eligibility is required for staff membership.

Do you have a minimum $100K/$300K liability limits, as required by our Medical Staff Bylaws? Yes _____ No_____  

Please describe your intended practice plan in Seguin. (Examples: solo or group, office location, cross coverage, types and volumes of patients expected, types and volumes of procedures you would like to perform, will you live in Seguin, from where do you expect to draw your patients, short and long term plans)

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

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________________________________________________________________________________________

Please inform us of any recognition, achievements, or distinctions you have earned as a health care provider. (Examples: Healthgrades, Blue Cross, other recognitions for excellent outcomes; recognitions for quality care, leadership or patient/staff relations)

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

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If you are interested in **Active Staff** privileges:

1. Please provide addresses and approximate driving distances from your home and office to Guadalupe Regional Medical Center.
   - Home Address: ___________________________________________ Distance: ________
   - Office Address: ___________________________________________ Distance: ________
   (Note: A drive time of no more than 30 minutes is an approximate expectation for most specialties.)

2. Have you explored potential arrangements for sharing in ER call with other established like specialties at GRMC? ______________ If yes, with whom? ________________________

3. Do you intend to be available as needed for patient care or referred by local physicians? ________________________________________________

4. Do you intend to impose any restrictions on types or payor-sources of patients? ________________________________________________

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If you are interested in **Consultant** privileges:

1. Please list the name and primary location of your practice or group, if applicable:
   __________________________________________________________________

2. If your practice’s primary location is not in Seguin please state how many days per month you plan to be available to consult on patients in Seguin? _____

3. As per the GRMC Bylaws, do you recognize that your privilege to treat patients is based on an Active Staff member’s request for consultation? ______

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If you are interested in **Cross Coverage** privileges please answer the following questions:

1. Please list the name and primary location of your practice group, if applicable:
   __________________________________________________________________
   a. If your group’s primary location is not in Seguin please state how many days per month you plan to be available to treat patients in Seguin? _____
   b. For which GRMC active staff member(s) will you be cross covering? ______________

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If you are interested in **Community Based** privileges please answer the following questions:

1. Are you willing to participate in unassigned call for post-discharge Emergency Room coverage as well as inpatient post-discharge follow up care? ____________________________

2. Are you currently “based exclusively in a local office practice”? ____________________________
   Please provide the address of that office: ______________________________________________

3. Community Based physicians subrogate their admitting privileges to an Active medical staff member, such as a hospitalist. Have you initiated any discussions for this coverage? ____
   If so, with who? __________________________________________________________
Please answer the following questions regardless of the type of privileges for which you wish to apply:

1. Has any hospital refused to grant you privileges for which you were eligible? _____
   a. Name the hospital: ______________________________________
   b. When were the privileges refused: __________________________
   c. List the reason(s) given for refusal of privileges: __________________________

2. How many practice groups have you worked with in the last five years? _______________
   a. If you were an employee of any practice group, have you ever been reprimanded, disciplined or fired? _____ If so, please state at which place of employment this occurred, the date on which it occurred, and the name of your supervisor. ____________________________________________________________

3. Have you ever been the subject of a peer review investigation by any practice group or hospital in the last five years? _____
   a. If so, what was the stated reason for the investigation? __________________________
   b. What was the outcome of any non-reported peer review investigation? ____________________________________________________________

4. Have you ever been reported to the National Practitioner Data Bank or the Medical Board of any state? _____
   a. If so, list the dates and basis for the report. ____________________________________________________________

5. Have you ever been arrested or convicted for any criminal charge?
   Arrested: ___________     Convicted: ___________
   a. If so, state the County, State, and date of the arrest and/or conviction, the charge involved, and the sentence.
      County and State: __________________________________________
      Date of Arrest/Date of Conviction: ____________________________
      Charge: __________________________________________________
      Sentence: _________________________________________________
   b. If you are currently on probation or parole, are you willing to provide documentation of the conditions of your release? ______

6. Have you ever used illegal drugs while practicing as a physician? _____
   a. Have you ever used illegal drugs while working or “on-call”? _____
   b. Have you used illegal drugs in the last month? _____

7. Are you willing to submit to drug testing prior to final approval of medical staff membership? ______

8. Has drinking ever impeded your ability to practice medicine? ______

9. Have you ever been required to or voluntarily participated in a substance abuse monitoring or rehabilitation program? ______
10. Have you been subject to monitoring by the Texas Medical Board or the Medical Board of any state? _____ If so, list the reasons, the beginning and ending dates of the monitoring.

   Dates: ___________________________________________________________________
   Reason(s): _______________________________________________________________

11. Has your DEA license or medical license from any state been suspended, restricted, revoked, or limited for any amount of time? _____ If so, please state the:
   a. Date of the action: ______________________________________________________
   b. The time frame of the action: ___________________________________________
   c. The state in which the action was taken: _________________________________
   d. The reason given for the action, i.e. failure to pay licensing fees, etc: ________

12. To your knowledge, are there any potential or pending lawsuits related to your practice of medicine? _____ If yes, please explain on a separate sheet.

13. Have you ever been served with a summons, complaint, written claim, or other document alleging professional negligence or other injury arising from your practice of medicine regardless of whether the complaint had merit? _____

   a. If so, please state the name of the complainant, when you received such notice, where you were practicing, and what was the alleged injury and negligence.
   _______________________________________________________________________
   b. Please state whether the complaint was resolved by withdrawal of the complaint, dismissal of a lawsuit, settlement, judgement or otherwise. ______________________________
   _______________________________________________________________________
   _______________________________________________________________________

14. Has your Medicare/Medicaid participation ever been suspended? _____

   a. If so, state the reason and the date of action? ______________________________
   _______________________________________________________________________
   b. When was your participation reinstated? _________________________________

15. Have you ever been accused of fraud, theft or sexual misconduct involving your medical practice, whether or not the complaint had merit? _____

   If so, please explain: _____________________________________________________
   _______________________________________________________________________

16. Has any insurance company declined to insure you for professional liability coverage, or issued insurance conditionally? _____

   If yes, please list the:
   a. Name of the company: ___________________________________________________
   b. The date of declination: _________________________________________________
   c. The date of conditional acceptance: _______________________________________
   d. The reason given for any declination or conditional acceptance: ______________
   _______________________________________________________________________

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17. Are you a citizen of the United States? _____ If not, please state what type of approval you have to work in the United States and when any Visa or Legal Residency status will expire.

________________________________________________________________________

I verify that the above statements are true and accurate.

__________________________________________________________
Printed Applicant Full Name     Signature of Applicant     Date

Applicant’s Office Phone: _________________________________

Applicant’s Email: _________________________________

PLEASE MAIL OR DROP OFF COMPLETED ELIGIBILITY SURVEY TO:

GUADALUPE REGIONAL MEDICAL CENTER
ROXANNE LANDIN, CREDENTIALING COORDINATOR
1215 E. COURT ST.
SEGUIN, TX 78155

(PLEASE DO NOT FAX; ORIGINALS ARE REQUIRED)

PLEASE DO NOT WRITE BELOW THIS LINE. MEDICAL STAFF SERVICES OFFICE USE ONLY.

Department Chairman or Credentials Committee Chairman comments: ________________________________

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Chairman Signature: ________________________________ Date: ________________________________