Hospital Medical/Surgical Facility
DENTIST

FACILITY INFORMATION

Facility name: ______________________ NHID: __________

Submission date: ______________ Requested start date: ______________

PERSONAL INFORMATION

First name: ______________ Middle name: ______________

Last name: ______________ Practitioner type: ______________

BUSINESS CONTACT INFORMATION

Professional/incorporated name: ______________________

Address: ______________________

City: ______________ Province: ______________

Postal code: ______________ Phone number: ______________

Email address: ______________________

HOME CONTACT INFORMATION

Address: ______________________

City: ______________ Province: ______________

Postal code: ______________ Phone number: ______________

Email address: ______________________

PREFERRED METHOD OF CONTACT

Mailing address: ☐ Business ☐ Home

Email: ☐ Business ☐ Home

Phone: ______________________

EMERGENCY CONTACT INFORMATION

First name: ______________ Last name: ______________

Relationship to applicant (optional): ______________ Phone number: ______________

Head of hospital department or division/senior medical administrator/program director

Name: ____________________ Organization: ____________________

Position: ____________________ Professional relationship: ____________________

City: ____________________ Email: ____________________

Phone number: ____________________ Extension: ____________________

Medical/dental colleague

Name: ____________________ Organization: ____________________

Position: ____________________ Professional relationship: ____________________

City: ____________________ Email: ____________________

Phone number: ____________________ Extension: ____________________

EDUCATION

Program type: ____________________ Degree/diploma: ____________________

Institution names 1.i78 0 0 0 10 59.mi 0 S Q BT 1 i /TT0 1 Tf 16 director ____________________

Institution name: ____________________

City: ____________________ Country: ____________________

From: ____________________ To: ____________________

Program type: ____________________ Degree/diploma: ____________________

Institution name: ____________________

City: ____________________ Country: ____________________

From: ____________________ To: ____________________

MEMBERSHIP IN PROFESSIONAL SOCIETIES

Society: ____________________ From: __________ To: __________

Society: ____________________ From: __________ To: __________

Society: ____________________ From: __________ To: __________

OTHER TRAINING SKILLS/CERTIFICATION

BLS (HCP or equivalent), ACLS, PALS, difficult airway course, laser training, radiation safety training, diplomas in advanced skills, etc.

Online BLS and ACLS certification and recertification courses without a classroom hands-on component led by a certified instructor are not accepted. Please note that BLS and ACLS certification are valid for two years from date of issuance.

Please provide a copy of all training documentation.

Course	Date issued	Attached
BLS (mandatory)	__________	☐
____________________	__________	☐
____________________	__________	☐

CURRENT REGISTRATIONS/LICENSES IN OTHER JURISDICTIONS

Jurisdiction: __________ Specialty: __________ From: __________ To: __________

Jurisdiction: __________ Specialty: __________ From: __________ To: __________

CURRENT ACADEMIC APPOINTMENTS

Institution name: ____________________

Department/specialty: ____________________ Academic rank: ____________________

Institution name: ____________________

Department/specialty: ____________________ Academic rank: ____________________

COMMITTEE MEMBERSHIP AND LEADERSHIP ROLES

Facility or program: ____________________

Committee/leadership role: ____________ From: ____________ To: ____________

Facility or program: ____________

Committee/leadership role: ____________ From: ____________ To: ____________

MEMBERSHIP(S) ON MEDICAL STAFF IN BRITISH COLUMBIA

Health authority, hospital, facility, or program: ____________

City: ____________ From: ____________ To: ____________

Privileges/practice activities: ____________

Health authority, hospital, facility, or program: ____________

City: ____________ From: ____________ To: ____________

Privileges/practice activities: ____________

OTHER RELEVANT EXPERIENCE

Institution name: ____________

City: ____________ Province/state: ____________ Country: ____________

From: ____________ To: ____________

Experience: ____________

WORK HISTORY

Hospital/non-hospital/organization: ____________

City: ____________ Province/state: ____________ Country: ____________

From: ____________ To: ____________ Position: ____________

Reason for leaving: ____________

Hospital/non-hospital/organization: ____________

City: ____________ Province/state: ____________ Country: ____________

From: ____________ To: ____________ Position: ____________

Reason for leaving: ____________

Hospital/non-hospital/organization: ____________

City: ____________ Province/state: ____________ Country: ____________

From: ____________ To: ____________ Position: ____________

Reason for leaving: ____________

DECLARATION FOR APPOINTMENT TO THE MEDICAL STAFF

1. Professional liability coverage or protection

   I declare that:

   ◯ I have professional liability protection through the Canadian Medical Protective Association (CMPA) that extends to all areas of my practice.

   ◯ I have professional liability protection through a policy of professional liability insurance from a BC-licensed company that provides coverage of at least $10 million and extends to all areas of my practice.

2. Have you ever had your health authority, hospital or non-hospital privileges revoked, suspended or restricted in any way, or have you surrendered or altered your privileges as a result of potential revocation, suspension or restriction?

APPLICANT ACKNOWLEDGEMENT AND CONSENT

I understand and agree that I have the burden of providing adequate information for the proper evaluation of my professional competence, character, ethics, qualifications, licensure, insurance and other qualifications and for responding to any inquiries about such information to the satisfaction of the non-hospital facility medical director.

I am a registrant in good standing with my professional College.

I agree to:

- abide by the Code of Ethics and Professionalism as adopted by my professional College at all times during my appointment to the medical staff.
- maintain and provide proof of professional liability insurance protection appropriate to my professional activities within the non-hospital facility.
- inform the non-hospital facility medical director of any changes that would affect my ability to practice medicine and the type of practice I undertake while a member of the medical staff (e.g. licensure, professional liability insurance coverage, my health, qualifications, immigration status).
- release the non-hospital facility, employees, agents, staff and medical staff from all liabilities and claims for losses sustained in connection with evaluating my application for medical staff membership, except where such losses are caused by their gross negligence or intentional misconduct.

I acknowledge that:

- I have read the College of Physicians and Surgeons of BC Bylaws, the NHMSFAP Standards and Policies and the Medical Staff Rules of the non-hospital facility regarding professional conduct and assessment.
- if appointed to the medical staff, I will fulfill my responsibilities as a member of the medical staff, as defined in the College Bylaws, the NHMSFAP Standards and Policies and the Medical Staff Rules of the non-hospital facility.
- any breach of the above agreement, or any misrepresentation or material omission on my part in completing this application may result in the denial, revocation or suspension of my appointment to the medical staff.

I understand that the non-hospital facility and the NHMSFAP will collect, use and disclose personal information about me for the purposes of:

- evaluating my application for medical staff membership.
- administering and maintaining my medical staff membership and relationship with the non-hospital facility including maintaining privileges/practice activities and access to information systems and equipment.
- non-hospital facility and NHMSFAP Committee planning.

I consent to the following:

- the non-hospital facility and NHMSFAP may contact the referees whose names I have provided for the purpose of evaluating my application for appointment/reappointment/employment and privileges/practice activities.
- my personal information will be stored by the non-hospital facility and the NHMSFAP and may be shared with other BC health authorities and their affiliates for the purposes stated above.

APPLICANT AUTHORIZATION

In signing this document:

- I acknowledge I have read and understand the points in the above declaration and acknowledgment.
- I declare that I have requested only those privileges for which by education, training and current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at the non-Hospital facility I am applying.
- I declare that the information submitted by me in this application is true to the best of my knowledge.

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MEDICAL DIRECTOR DECLARATION AND RECOMMENDATION FOR APPOINTMENT

In signing this document:

- I acknowledge I have reviewed this medical staff application for appointment, requested clinical privileges and supporting documentation.
- I acknowledge that I am responsible for notifying the Non-Hospital Medical and Surgical Facility Accreditation