Request for Application Form

Please Type or Print:

Name ____________________ Specialty/Subspecialty ____________________

Primary Office Address (Street) ____________________ City, State, Zip ____________________

Office Telephone Number ____________________ Office Fax Number ____________________

Practice Name ____________________ Email Address ____________________

Date of Birth: ____________________ NPI #: ____________________

Mailing address for application (if different from primary office:

____

Credentialing Contact, if applicable: ____________________ Name

Office Telephone Number ____________________ Email Address ____________________

Please list the entities for which you are requesting an application:

☐ Petaluma Valley Hospital, Petaluma, CA
☐ Queen of the Valley Medical Center, Napa, CA
☐ Redwood Memorial Hospital, Fortuna, CA
☐ Santa Rosa Memorial Hospital, Santa Rosa, CA
☐ St. Joseph Hospital, Eureka, CA
☐ St. Joseph Health Hospice & Palliative Care

Please indicate which staff category you are requesting: ☐ Active ☐ Courtesy ☐ Community Affiliate ☐ Telemedicine ☐ Allied Health Professional

If you are requesting Active or Courtesy privileges, do you have documentation of current clinical activity in an acute care setting within the previous 24 months? ☐ Yes ☐ No

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Are you in or joining a group practice? ☐ Yes ☐ No If so, Practice Name: ____________________

State your reasons for requesting an application for St. Joseph Health Target Start Date: ____________________

Please provide the following information:

Residency Completed in: ____________________ Year Completed: ________

Fellowship Completed in: ____________________ Year Completed: ________

Are you currently enrolled in a residency or fellowship program? ☐ Yes ☐ No

Board Certification: (Please note: Specific facilities may require all members of the medical staff to be board certified or show intent to become board certified in the specialty or subspecialty that is the primary focus of their medical practice within five (5) years of residency completion or within the specific interval of time specified by the applicant's specialty, whichever is less).

Are you certified by one of the Boards of the American Board of Medical Specialties? ☐ Yes ☐ No
If NO, do you qualify to sit for the American Board of Medical Specialties exam? ☐ Yes ☐ No
Date examination scheduled:_________________________
If NO, did you complete an ACGME-approved training program? ☐ Yes ☐ No

Are you certified by one of the Boards of the American Osteopathic Association? ☐ Yes ☐ No
If NO, do you qualify to sit for the American Osteopathic Association Boards? ☐ Yes ☐ No
Date examination scheduled:_________________________
If NO, did you complete an AOA-approved training program? ☐ Yes ☐ No

Are you certified by another Board? ☐ Yes ☐ No

If YES, what Board? ____

Certified in: ____

RELEASE FROM LIABILITY:

My signature below indicates that the statements above are true, that I will responsible to update and keep information current by submitted written changes that materially effect this request and/or future applications. Failure to do so shall be grounds for denial of application, nullification of approval if granted and/or termination of membership and/or clinical privileges. I request an application for appointment and/or clinical privileges at one or more St. Joseph Health Nor Cal facilities. I certify that I meet the criteria for membership and clinical privileges at one or more St. Joseph Health Nor Cal facilities. I understand that this request in no way obligates SJH and/or the Medical Staff(s) to send me an application, or to provide due process procedures in the event of denial of my request for an application. I understand that if my application request is denied due to failure to meet the minimum qualifications of the hospital or clinical departments, or any other reason, the hearing and appellate review procedures are not applicable. I hereby release from liability any representative of SJH and its facilities Medical Staff(s) for their acts performed in good faith and without malice in connection with evaluating my request for an application to the Medical Staff(s). I hereby release from liability any and all individuals and organizations who provide information to the hospital, or its Medical Staff(s) concerning my professional competence, ethics, character, and other qualifications and, hereby consent to the release of such information.

____ _____________________
Signature of Applicant Date

Please mail, fax (707-525-5280), or email (CAL-SRM-MSS@stjoe.org) this request for an application to:

St. Joseph Health – Northern California Region
Centralized Credentials Verification Organization
1165 Montgomery Drive, Suite 1W04
Santa Rosa, CA 95405
707-547-5471

FOR OFFICE USE ONLY

Application Sent: ____/____/____ By: ____________

Rev: 05/09/2018 PTB