

San Ramon Regional Medical Center

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Medical Staff Office
6001 Norris Canyon Road
San Ramon, CA 94583
(925) 275-8265 Phone
(925) 275-8395 Fax

Request for Medical Staff Application

Please complete the following information so that an application packet for medical staff membership and privileges can be forwarded to you. We appreciate your interest in San Ramon Regional Medical Center.

Please review the following Bylaws language regarding qualifications for membership and check (✓):

- Be licensed in the State of California and have a federal DEA certificate, if applicable. Applicants whose license to practice in the State of California is restricted or encumbered by the Medical Board of California, the Board of Osteopathic Examiners or any other licensing agency, shall not be considered for initial appointment to the Medical Staff.
- Except for dentists, be Board Certified and have practiced in the applicant's intended field of practice in a Joint Commission (or equivalent) accredited acute care hospital for two (2) of the previous three (3) years, or have completed a residency in the intended field of practice within the previous eighteen (18) months.
- Have liability insurance coverage, with an insurer acceptable to the Governing Board and Medical Executive Committee, at minimum coverage limits as from time to time may be jointly determined by the Medical Executive Committee and the Governing Board, currently \$1 million/ \$3 million aggregate.
- Except applicants and physicians assigned specific times to be at the facility (e.g., emergency department physicians), resides in a geographic location that allows the applicant to provide for continuous care and supervision of patients.
- Must not be excluded from participating in Medicare, Medicaid, or any other federal healthcare program when such exclusion has been imposed by government enforcement authorities, or accepted by practitioner, as a sanction for unlawful conduct.

Attestation and Signature

By making this request, I hereby attest that I meet the minimum threshold criteria for this request as outlined above.

Practitioner's signature: _____ Date: _____

| APPLICANT INFORMATION – <i>It is required that you complete all fields below.</i> | | | |
|--|--------------|----------------------------|---------|
| Last Name: | | First: | Middle: |
| Mailing Address: | | City: | |
| | | State: | ZIP: |
| Telephone Number: | DOB: | E-Mail Address: | |
| Fax Number: | Cell Number: | Board Certified Specialty: | NPI: |

Should you have any questions, please contact the Medical Staff Office at (925) 275-8265.