
***CARROLL COUNTY MEMORIAL HOSPITAL***
1502 North Jefferson | Carrollton, Missouri 64633 | Phone: (660) 542-1695 | Fax: (660) 542-1944

# *PRE-APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF*

Dear Practitioner:

Thank you for your interest in Carroll County Memorial Hospital. We would like to take this opportunity to tell you about our application process, should you wish to apply for membership/privileges at our facility.

The attached pre-application contains the minimum requirements to be eligible for Medical Staff Membership and/or privileges. Credentialing new applicants is a two-step process at Carroll County Memorial Hospital. The first step is completion of the pre-application form and returning it to the Medical Staff Office located at:

Carroll County Memorial Hospital
Medical Staff Office
1502 North Jefferson
Carrollton, MO 64633
Fax: 660-542-1944
Email: credentialing@ccmhospital.org

After review for eligibility, which includes verification of Missouri licensure, qualifications, and adequate facilities/services at the facility, an application will be provided to you by either mail or email. The second step of the credentialing process is submission of the actual application to Carroll County Memorial Hospital where verification of the application and its content can take up to 60 days. Should you have any questions, or would like to contact the Medical Staff Office, please contact us at 660-329-6065 or by email at credentialing@ccmhospital.org.

The pre-application and all of its supporting documents and policies are available on our website, www.carrollcountyhospital.org under the "Medical Professionals" section.

Sincerely,

Cassy Buehler

Cassy Buehler
Credentialing Specialist

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## *PRE-APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF*

Full Name: _____ Professional Degree: _____

Date of Birth: _____ Social Security Number: _____

Office Name: _____

Office Address: _____
Street City State Zip Code

Residence Address: _____
Street City State Zip Code

Office Telephone: _____ Residence Telephone: _____

Missouri License: _____ NPI Number: _____

## EDUCATION & TRAINING

**Medical School**: _____
Name Dates Attended Degree

**Internship:** _____
Name Dates Attended Specialty

**Residency:** _____
Name Dates Attended Specialty

**Fellowship:** _____
Name Dates Attended Specialty

**Other**: _____
Name Dates Attended Degree

**SPECIALTY: (**Please select your specialty as well as any privileges you would like to request.)

- ☐ Allergy and Immunology
- ☐ Cardiovascular
- ☐ Dentist
- ☐ Dermatology
- ☐ Dermatology - Telehealth
- ☐ Emergency Medicine
- ☐ Family Practice
- ☐ Gastroenterology
- ☐ General Surgery
- ☐ Nephrology - Telehealth
- ☐ Neurology
- ☐ Obstetrics and Gynecology
- ☐ Oncology
- ☐ Orthopedic Surgery
- ☐ Otolaryngology
- ☐ Pain Management
- ☐ Pathology
- ☐ Podiatry
- ☐ Psychiatry
- ☐ Pulmonary
- ☐ Radiology
- ☐ Rheumatology
- ☐ Urology
- ☐ Vascular Surgery
- ☐ Other: _____

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**SUPPORTING DOCUMENTS:**

This form must be returned with copies of the following documents:

- Current Missouri license to practice medicine;
- DEA certificate (if applicable);
- Professional liability insurance policy certificate with minimum amount of coverage in the amount of $1,000,000/3,000,000 from insurance carrier;
- ECFMG certificate (if foreign medical graduate);

**ATTESTATION/SIGNATURE:**

By signing this pre-application, I hereby request an application for appointment to the Medical Staff of Carroll County Memorial Hospital. I understand that completing this Pre-Application in no way obligates the hospital and/or medical staff to afford me medical staff membership or privileges. I understand that no individual is entitled to a hearing, or any other procedural right, as a result of a refusal to provide the prospective applicant an Application form for appointment to the Medical Staff at Carroll County Memorial Hospital.

As an applicant for staff appointment and privileges, I understand that it is my responsibility to produce adequate information so Carroll County Memorial Hospital can perform a proper evaluation of my application. I agree to provide Carroll County Memorial Hospital with updated information regarding all questions on this pre-application form as new information becomes available. I also agree to provide Carroll County Memorial Hospital with additional information that one of its authorized representatives may request. Failure to produce any requested information will prevent my application from being processed. As part of this request for application, I authorize Carroll County Memorial Hospital to obtain references on my qualifications and current clinical competence.

_____
Applicant Printed Name

_____
Applicant Signature

_____
Date