Mayagüez Medical Center
Dr. Ramón Emeterio Betances

APPLICATION FOR REAPPOINTMENT TO THE MEDICAL STAFF

Hospital MAYAGUEZ MEDICAL CENTER	**Location** MAYAGUEZ, PUERTO RICO	**Term from:** _____ **to** _____

IDENTIFYING INFORMATION	Last Name	First Name	Initial	Department		
	Specialty		Subspecialty			
CURRENT ADDRESSES: (Please complete. It is important to have updated information in file).						
RESIDENCE ADDRESS	Address	City	State	Zip Code	Phone or Cell	
	Email Home					
OFFICE ADDRESS	Address	City	State	Zip Code	Phone or Cell	
	Email Office					

MEDICAL STAFF CATEGORY REQUESTED - Check One [✓] (Refer to your attached privilege list for current status)

☐ **Active** ☐ **Consulting** ☐ **Courtesy**

PRIVILEGES DESIRED AND REQUESTED	☐ Anesthesia ☐ Dental ☐ Emergency Room ☐ Family Medicine	☐ Internal Medicine ☐ Nuclear Medicine & Radiotherapy ☐ Obstetrical & Gynecological	☐ Orthopedic ☐ Pathology ☐ Pediatric ☐ Radiology	☐ Surgical ☐ Other (specify) _____ _____
SPECIFIC PRIVILEGES	**Other Specific Privileges & Special Procedures (not included as Core Privileges in your Specialty) requested are detailed on separate sheet** ☐ No ☐ Yes, and supporting education certificates are supplied			

List all present and previous hospital affiliations and medical staff memberships, in chronological order (include assistantships and appointments). Specify all departments in which privileges were exercised. "See CV" is not acceptable.

AFFILIATIONS	Name and Location of Hospital	Status	Dates
	Name and Location of Hospital	Status	Dates
	Name and Location of Hospital	Status	Dates
	Name and Location of Hospital	Status	Dates

CERTIFICATION	Are you Certified? ☐ Yes ☐ No		Dates (From / To)
	Certified by American Board of (Name of Board)		
	Board Qualified (Name of Board)		
LIABILITY INSURANCE	Amount of Coverage	Insurance Carrier	
	Policy No.	Expiration Date	

ANSWER THE FOLLOWING QUESTIONS AS THEY APPLY TO THE LAST YEAR

a. Has your professional liability insurance coverage been terminated by action of the insurance company? Yes ☐ No ☐
b. Have any professional liability suits or claims been filed against you? Yes ☐ No ☐
c. Has any professional liability suits or claims been filed against you which are presently pending? Yes ☐ No ☐
d. Have any judgments or settlements been made against you in in professional liability cases? Yes ☐ No ☐

PROFESSIONAL LIABILITY DETAIL SHEET (Please copy this page if additional sheets are needed)

If the answer is ***yes*** to any of the above questions, please fill in the following details for each pending or settled malpractice suit or claim you have experienced.

☐ Pending ☐ Settled Date: _____

List the allegations: _____

Case number / title: _____

Court case took place: _____

IF ANSWER TO ANY OF THE FOLLOWING QUIESTIONS IS YES, PLEASE GIVE FULL DETAILS ON SEPARATE SHEET

a. Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked? Yes ☐ No ☐
b. Have you ever been refused membership on a hospital medical staff? Yes ☐ No ☐
c. Has your request for any specific clinical privileges ever been denied, or granted with stated limitations? Yes ☐ No ☐
d. Have your privileges at any hospital ever been suspended, diminished, revoked, not renewed or voluntarily renounced (other than inactivity)? Yes ☐ No ☐
e. Has your narcotics registrations ever been suspended or revoked? Yes ☐ No ☐
f. Have you ever been denied membership or renewal thereof, or been subject to disciplinary actions in any medical organization? Yes ☐ No ☐

THE FOLLOWING DOCUMENTATION MUST BE INCLUDED WITH THE COMPLETED REAPPLICATION:

	PAST DUE DOCUMENTS	EXPIRATION DATE
	Malpractice Insurance	
	DEA	
	ASSMCA	
	Health Certificate (Original)	
	Registry	
	Certification of the College of Physicians Surgeon of P.R.	
	Good Standing	
	CPR/ACLS/PALS/ATLS/NALS/BTLS	
	$100.00 Annual Fee (Payable to ***Facultad Médica MMC***)	
	Certificate of No Penal Record	
	Hepatitis B Vaccine Evidence	
	Varicella Vaccine Evidence	

I hereby request reappointment to the Medical Staff of ***Mayaguez Medical Center***. I agree to report any changes in my health status that would affect my ability to practice medicine. I attest that my training and experience qualifies me to perform the clinical privileges that I have requested and I agree to abide by the Medical Staff and Hospital By-Laws, Rules and Regulations and Policies. I certify that the information I have supplied herein is complete and correct.

Date _____ Signature of Applicant _____