



September 29, 2011

Thank you for your interest in applying for appointment to the Medical Staff at **Plaza Medical Center of Ft. Worth.**

Applications to the medical staff or allied health staff are being provided to those individuals who meet the requirements listed on the attached sheet. Please be aware that these are base line standards.

1. Currently licensed by the State of Texas.
2. Maintain a Federal DEA (Drug Enforcement Agency) number if prescribing scheduled substances and a statement of any restrictions, if applicable. ***NOTE: Your current Texas office address MUST be listed on your DEA certificate before your application is presented to our Credentials committee for recommendation of privileges.***
3. Carry professional liability insurance coverage in an amount specified by the **Plaza Medical Center**, Board of Trustees. (Minimum requirement at present is \$200,000/600,000.)
4. Satisfactory completion of an approved post-graduate residency training program and/or fellowship, if applicable. (See attached requirements).
5. Board certification or eligibility to obtain board certification within five years of completion of residency training program.
6. Established or plan to establish an office and residence within thirty (30) minutes of the hospital to facilitate adequate and continuous patient care.

The attached HCA delegate form, recent photograph, and C.V. must accompany the pre-application. Please complete the application request form in its entirety and return it within 20 days. After a review of the form and its documents, an application packet will be forwarded to you from our Shared Services Center in Houston.

Please note: **Plaza charges a fee of \$300 for any new applicant to the Medical Staff and \$200 for Advanced Practice Professionals.**

If you have any questions or we can be of assistance in any way, please do not hesitate to call (817) 347-5859. You may return this pre-application via fax to 817-347-5793.

Sincerely,  
*Medical Staff Office*

# PLAZA MEDICAL CENTER OF FORT WORTH

**Minimum criteria** for any practitioner requesting appointment to the Medical Staff at Plaza Medical Center of Fort Worth is successful **completion of an ACGME/AOA approved residency program and/or fellowship program** leading to Board Certification. Do not submit this pre-app unless you have completed your training program OR you are within 60 days of completion. **The HCO Credentialing Online – Provider’s Authorization for Delegate form** is also required for the Shared Services Center – Houston. Plaza MSO will also require the Physician Dictation form for Medical Records and the MRSA statement completed and returned. The following list shows the minimum acceptable years of training for various specialties. **PLEASE CIRCLE ONE.**

- |   |                    |
|---|--------------------|
| Family Practice                         | Neurosurgery       |
| Cardio-Thoracic                         | General Surgery    |
| Vascular                                | Internal Medicine  |
| Anesthesiology                          | Gastroenterology   |
| Ophthalmology                           | Pulmonology        |
| Otolaryngology                          | Endocrinology      |
| Orthopedics                             | Nephrology         |
| Plastic Surgery                         | Oncology           |
| Colon/rectal Surgery                    | Pediatrics         |
| Podiatry                                | Pathology          |
| Dermatology                             | Psychiatry         |
| Oral Surgery                            | Radiology          |
| Urology                                 | Obstetrics         |
| Physical Medicine                       | Gynecology         |
| Cardiology                              | Intv’l Cardiology  |
| Advanced Practice<br>Professional _____ | Neurology          |
|   | Emergency Medicine |

Pre-applications submitted that do not meet the criteria noted above will not be issued an application to the Medical Staff. If your postgraduate training was completed at a time when the number of years required for Board Certification was different than those indicated above, please provide additional explanation. Board Certification is now required within 5 years of completion of training.

NAME: \_\_\_\_\_ NPI: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

EMAIL: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

HOME PHONE or CELL #: \_\_\_\_\_

OFFICE ADDRESS: \_\_\_\_\_

OFFICE PHONE #: \_\_\_\_\_ OFFICE FAX #: \_\_\_\_\_

CREDENTIALING CONTACT: \_\_\_\_\_

MEDICAL SCHOOL: \_\_\_\_\_ DATE OF GRADUATION: \_\_\_\_\_

SPECIALTY: \_\_\_\_\_

NAME OF BOARD: \_\_\_\_\_ DATE CERTIFIED: \_\_\_\_\_

\*DEA NUMBER: \_\_\_\_\_ CATEGORY (Active, Courtesy, Consulting, Affiliate): \_\_\_\_\_

List States where licensed and permit number:

STATE	NUMBER	STATE	NUMBER

**PROFESSIONAL LICENSES/CONTROLLED SUBSTANCES PERMITS AND CERTIFICATES**

1. Have you been denied a professional license by any State licensing board or agency?  Yes  No
2. Has your license to practice medicine in any State been reduced, suspended, limited, revoked, canceled or otherwise diminished in any manner?  Yes  No
3. Have you been the subject of any disciplinary action or proceeding by any licensing or regulatory agency or State Board including, but not limited to, reprimands, probation, monitoring, limitation of practice or procedures, or mandatory second opinions?  Yes  No
4. Are there any pending actions, proceedings or investigations related to your professional license?  Yes  No

If the answer to any of the above questions is yes, please explain

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 I authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me and/or my professional competence to give such information to **Plaza Medical Center of Fort Worth** or authorized representative. A photostatic copy of this authorization shall be as valid as the original.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_

Please return form to:  
**PLAZA MEDICAL CENTER of Fort Worth**  
**Medical Staff Services**  
 900 8th Avenue \* Fort Worth, Texas 76104