

Commonwealth CredentialingSM

Pre-Application Request Form (ALL SPACES MUST BE COMPLETED)

Approved	Date
BPSC _____	_____
CBH _____	_____
LSC _____	_____
KSC _____	_____
SAM _____	_____
SJE _____	_____
SJH _____	_____

For Office Use Only

Name of Applicant: _____

MD DO DMD Other _____ Last
 _____ First Middle
 DOB: _____ Gender _____

Current Mailing Address: _____ Phone: _____

_____ Number and Street
 _____ City _____ State _____ Zip
 Fax: _____

Email Address: _____

Medical School _____ Degree _____ Dates: _____

Post Graduate _____ / _____ / _____ Type Program Institution/State Dates: From _____ To _____
 _____ / _____ / _____ Type Program Institution/State Dates: From _____ To _____

_____ / _____ / _____ Type Program Institution/State Dates: From _____ To _____
 _____ / _____ / _____ Type Program Institution/State Dates: From _____ To _____

Any gaps in training must be explained on a separate sheet of paper.

Practice/Group Joining: _____ Anticipated Start Date: _____

Practice Address: _____

Practice Phone: _____ Fax: _____ Practice: Solo Group

My practice is/will be located in Lexington My practice is/will be located within _____ miles of Lexington
 My residence is/will be located in Lexington My residence is/will be located within _____ miles of Lexington

Please mail my Initial Application to my: Current Address Practice Address Other Address (separate page)

Certified by American Board of _____ Expiration Date: _____

If not board certified, provide explanation/board eligibility date _____

Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (e.g. Medicare, Medicaid)? Yes No

Please indicate below the specialty(s) in which you are requesting appointment.

I am applying for appointment at:

Baptist-Physicians' Surgery Center (BPSC)	<input type="checkbox"/>	UK Healthcare Good Samaritan Hospital (SAM)	<input type="checkbox"/>
Central Baptist (CBH) (requires backup coverage)	<input type="checkbox"/>	Saint Joseph Health System (SJHS):	
Lexington Surgery Center (LSC)	<input type="checkbox"/>	St. Joseph East (SJE)	<input type="checkbox"/>
Kentucky Surgery Center (KSC)	<input type="checkbox"/>	Saint Joseph Hospital (SJH)	<input type="checkbox"/>

Primary Hospital where I hold admitting privileges _____

By completion of this pre-application I understand that this form will be reviewed by the facility(s) indicated above and if all criteria is met and no Exclusive Contracts are in place for my requested privileges then I will be sent an initial appointment application. I understand that completing this form will in no way obligate the facility(s) at which I am applying for privileges to afford me medical staff membership or privileges.

I hereby acknowledge that in the event this pre-application is denied, I will not receive an application for appointment. I further acknowledge and agree that denial is not a professional review action and does not entitle me to any fair hearing or review rights under the facility(s) Bylaws, nor is it considered to be reportable to the National Practitioner Data Bank.

I also certify that to the best of my knowledge the information above is complete and accurate and acknowledge that any omission or misrepresentation shall constitute sufficient cause for denial of my request for an application for appointment.