Peoria Medical Society

Request for Additional Information

Please print or type.
All blanks must be filled in or marked N/A (Non-Applicable).

When do you wish to obtain Hospital Staff Privileges by? _____

Please check (x) the appropriate box(es). **ONLY** apply to those hospitals/institutions where you will be practicing.

You are seeking appointment to:

- ☐ **Center for Health Ambulatory Surgery Center, LLC**
- ☐ **Central Illinois Endoscopy Center**
- ☐ **Graham Health System - Canton, IL**
- ☐ **Human Service Center**
- ☐ **OSF Saint Francis Medical Center**
- ☐ **OSF Saint James - John W. Albrecht Medical Ctr**
- ☐ **Peoria Ambulatory Surgery Center**
- ☐ **Peoria Day Surgery Center**
- ☐ **Proctor First Care /Proctor Health Systems, Inc.**
- ☐ **Renal Intervention Center/Renal Care Associates**
- ☐ **UnityPoint Health - Methodist**
- ☐ **UnityPoint Health - Proctor**

You are requesting privileges in the following departments _____
Is your practice limited to a specialty or sub-specialty? ☐ Yes ☐ No
If yes, please indicate: _____

Personal Identification Data

Name _____
Maiden Name(s) _____
Local Home Address _____
City/State/ZIP _____
Local Home Phone # _____
Home Email Address _____

Alternate/Backup Physician Coverage Information

Physician's Name(s) _____
Pager # _____ Phone # _____
Group Name _____
Address _____
City _____ State _____ ZIP _____

Please Enclose the Following

1. Signed CME Attestation.
2. Photo(s) for each institution you are seeking privileges.
3. Photo for the Peoria Medical Society file.

OPTIONAL INFORMATION:

Marital Status — Single ☐ Married ☐ Widowed ☐ Divorced ☐
Name of Spouse _____

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ADVERSE OR OTHER ACTIONS

Submit with all applications. Please answer the following questions to the best of your knowledge with a "yes" or "no". If you answer "yes" to questions(s) 1 or 2, please provide an explanation below or on an additional sheet of paper.

1.) Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgical center membership for any reason? (If yes, please explain on a separate page)

_____Yes _____No

2.) Do you have any restrictive endorsements on your malpractice insurance coverage?

(If yes, please explain and/or list exclusions on a separate page)

_____Yes _____No

3.) Are the majority of the CME credits that you have obtained as required by the Medical Practice Act to maintain your Illinois State Medical License directly related to the clinical privileges your are requesting?
(If "no", please provide an explanation on a separate page.)

_____Yes _____No

Note: Proof of attendance and program content for CME credits must be submitted upon request. (Not applicable for Residents, Fellows, Allied Health Professionals or those who just obtained their license.)

TB Testing & Pertussis Vaccination

4.) Please provide proof of a current (within the past year) TB test.

5.) Please provide proof of pertussis/TdAP vaccination

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6.) Please be advised that the local hospitals require completion of a background check as part of the credentialing process. This includes but is not limited to a county, state, and federal criminal search, a driving record, and a social security trace.

Please answer all questions throughout the application fully and truthfully. The questions on pages 19-21 are clear and concise, such as have you **ever been charged with, convicted of**, or **are there any currently pending** actions. If you are unsure of how to answer a specific question, please err on the side of offering more information rather than less. Any misrepresentation or omission from the application, whether intentional or not, may be cause for immediate cessation of the appointment process. Forms A through F provide the applicant the opportunity to explain specific details and disposition of each occurrence, incident, or circumstance. Specific questions should be addressed to the Peoria Medical Society or the Medical Staff Office of participating facilities.