

# Saint Clare's Hospital

## MEDICAL STAFF PRE-APPLICATION FORM

Date: \_\_\_\_\_

Name in Full: \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone Number \_\_\_\_\_ Beeper Number \_\_\_\_\_

Residence Address: \_\_\_\_\_

Residence Phone Number \_\_\_\_\_

Department \_\_\_\_\_ Subspecialty \_\_\_\_\_

### 1. BOARD CERTIFICATION STATUS

1.1 Are you Board Certified in the specialty you anticipate practicing?  Yes  No

1.2 If yes, please state the name of Board \_\_\_\_\_

1.3 If no, have you taken the requisite amount of training to classify you as being qualified to take the boards in your specialty and are you eligible to take the Boards now?

Yes  No

1.4 If no, when will you have completed your training and be eligible to take your Boards?

\_\_\_\_\_

1.5 Do you plan to take the Board certification examination?  Yes  No

1.6 When do you plan to take the examination? \_\_\_\_\_

### 2. LOCATION OF PRACTICE

2.1 Do you plan to establish or have you established an office?  Yes  No

Where: \_\_\_\_\_

2.2 When will office hours begin at the location? \_\_\_\_\_

3. HOSPITAL AFFILIATION

3.1 Are you planning to apply for appointment and clinical privileges or do you hold privileges at any other hospital? Yes No

Where? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3.2 For what percentage of your total hospital practice do you anticipate using the facilities at Saint Clare's Hospital. \_\_\_\_\_

I request an application for appointment to the Medical Staff of Saint Clare's Hospital.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE BE SURE TO SIGN, DATE AND RETURN VIA FACSIMILIE TO 973-625-6457; OR,  
MAIL TO: SAINT CLARE'S HOSPITAL, 25 POCONO ROAD, DENVILLE, NJ 07834  
ATTENTION: MEDICAL STAFF OFFICE**