North Kansas City Hospital

Dear Doctor:

Thank you for your interest in North Kansas City Hospital. Our Hospital has adopted the following basic membership criteria to assist our Medical Staff to achieve a high standard of patient care. A potential applicant for Medical Staff membership must:

- Be a M.D., D.O., D.D.S., or D.P.M.
- Be Board Certified or be Board Eligible and be in the process of becoming Board Certified (within 6 years of completion of approved residency program)
- Hold a current state license in the state of Missouri
- Have a valid federal DEA Controlled Substances Registration Certificate that is registered in the state of Missouri, and a Missouri Bureau of Narcotics and Dangerous Drugs Controlled Substances Registration Certificate
- Maintain professional liability insurance in at least the amount that the state of Missouri requires ($500,000 per occurrence)
- Have an intended practice plan and plan to establish an office within 30 minutes of the Hospital to allow for continuous patient care within the community that the Hospital serves.

Medical Staff Services uses an online Pre-Application process to determine whether prospective applicants meet our basic criteria for Medical Staff membership and privileges, and to determine whether we can accommodate prospective applicants. Please complete the Pre-Application form and return it to Medical Staff Services along with a copy of your curriculum vitae.

The Medical Staff Services Department is a paperless department and has eliminated their paper-based application process using the AppCentral website. Now Medical Staff Services receives completed applications for membership online only through AppCentral.

Your Pre-Application form and accompanying documentation will be reviewed and if you meet our basic membership criteria, ***you will receive an "invitation" directing you to the AppCentral website*** so that you can complete the Application for Membership to the Medical Staff and the appropriate Delineation of Clinical Privileges request form online. You will also receive an invoice for a non-refundable application processing fee of Five Hundred Dollars ($500) payable to North Kansas City Hospital by check. Your application is not considered ***complete*** until this fee has been received in Medical Staff Services.

We will review your credentials thoroughly before making a recommendation to the NKCH Board of Trustees regarding your appointment to the Medical Staff. All members of the Medical Staff except Affiliate Staff are assessed annual dues in the amount of Three Hundred Dollars ($300). Once appointed to the Medical Staff of North Kansas City Hospital, you will receive a dues notice by mail allowing you 30 days until your dues payment is due. Medical Staff dues are assessed at the beginning of each fiscal year on July 1st and each new applicant's dues is pro-rated depending on their actual appointment date.
Please do not hesitate to contact Medical Staff Services at 816.691.2050 if you need assistance.

PRE-APPLICATION FORM AND INTENDED PRACTICE PLAN
(Please note - this is **NOT an application for Medical Staff Membership)**

Name In Full: _____

Social Security #: _____ Date of Birth: _____

Credentialing Email: _____

Personal Email: _____

Office Address: _____

Office Telephone: _____

Residence Address: _____

Residence Telephone: _____ Check Here If Silent ( )

Proof of Professional Liability Insurance with a minimum of $500,000 per occurrence? __YES __NO

CAQH: _____ NPI: _____ Meritas ID #: _____

MO State License #: _____ Expiration Date: _____

MO DEA #: _____ Expiration Date: _____

MO BNDD #: _____ Expiration Date: _____

Board Certification

Each applicant for membership to the Medical Staff shall have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in a specialty in which the applicant seeks clinical privileges, or a dental surgery training program accredited by the Commission on Dental Education of the American Dental Association, or a podiatric surgical residency program accredited by the Council on Podiatric Education of the American Podiatry Association.

Each applicant for membership to the Medical Staff shall become certified within six years of completion of residency training by the appropriate specialty board of the American Board of Medical Specialties, The American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, as applicable, and shall maintain such board certification as a condition of remaining a member of the Medical Staff.

Are you Board Certified? ___ YES ___ NO

If "NO," are you eligible for Board Certification? ____ YES ____ NO
If Board Eligible, list date you anticipate sitting for the examination: _____

Please indicate the clinical specialty in which you desire appointment and clinical privileges:

SPECIALTY:

__ Allergy & Immunology
__ Anesthesiology
__ Cardiovascular Disease
__ Cardiothoracic Surgery
__ Colon & Rectal Surgery
__ Dentistry
__ Dermatology
__ Emergency Medicine
__ Endocrinology
__ Family Practice
__ Gastroenterology
__ General Surgery
__ Gynecology
__ Hematology/Oncology
__ Hospice & Palliative Medicine
__ Infectious Disease
__ Internal Medicine
__ Neonatology
__ Nephrology
__ Neurodiagnostic Remote Monitoring
__ Neurology
__ Neurosurgery
__ Obstetrics & Gynecology
__ Ophthalmology
__ Oral & Maxillofacial Surgery
__ Orthopedic Surgery
__ Otolaryngology
__ Pain Management
__ Pathology
__ Pediatric Cardiology
__ Pediatrics
__ Perinatology
__ Physical Medicine & Rehab
__ Plastic Surgery
__ Podiatry
__ Psychiatry
__ Pulmonary Medicine
__ Radiation Oncology
__ Radiology
__ Rheumatology
__ Tele - Neurology
__ Tele - Psychiatry
__ Tele - Radiology
__ Trauma Surgical Critical Care
__ Uro-Gynecology
__ Urology
__ Vascular Surgery
__Wound Healing & Hyperbaric Med

Other: _____

___ Place a check here to indicate if you are applying to Affiliate Staff (membership without privileges).

Please Note: Should you be appointed to North Kansas City Hospital's Medical Staff, you will be assigned a category. Please check below to indicate the staff category you are applying for:

___Active Staff
___Courtesy Staff
___Consulting Staff
___Coverage Staff
___Affiliate Staff

The following is an excerpt from North Kansas City Hospital's Medical Staff Bylaws regarding the Medical Staff Category for Active Staff appointment:

> *"Active Staff members must assume all the responsibilities of membership in the Active Staff, including: 1) Providing specialty coverage for the Emergency Department and providing care for unassigned patients"*

Please describe your medical education / training:

Medical School: _____

Date of Graduation: _____

Internship: _____
(Specialty)

Dates: From _____ To _____

Residency: _____
(Specialty)

Dates: From _____ To _____

Fellowship: _____
(Specialty)

Dates: From _____ To _____

Where do you currently have medical staff appointment and clinical privileges?

Facility	Specialty	Category or Status of Appointment

INTENDED PRACTICE PLAN

Expectations:
I intend to assist North Kansas City Hospital ("NKCH") to fulfill its mission in the following manner:

___ YES ___NO 1. Meet community needs by providing medical services within the NKCH service area in a manner that takes into account the clinical needs of patients and the convenience of community residents.

___ YES ___NO 2. Have at least the minimum number of patient contacts at NKCH necessary to enable the NKCH Medical Staff to evaluate and ensure clinical competence (the Particular number necessary will be determined or approved by the Medical Executive Committee and shall have a reasonable medical basis).

___ YES ___NO 3. Take Emergency Call and assist NKCH to provide emergency services to patients in need.

___ YES ___NO 4. Arrange for the availability of an alternate practitioner who is a member of the NKCH Medical Staff to provide ongoing care to my patients in the event of my absence or unavailability.

___ YES ___NO 5. Participate in Medical Staff and NKCH committees if appointed or requested.

___ YES ___NO 6. Comply with NKCH CME requirements.

Affiliations / Practice Information

___ YES ___NO 1. I am employed or independently contracted by a hospital or hospital-owned entity other than NKCH or Meritas Health Corporation. If "Yes", please indicate your employer: _____

2. Please list the physician practice / group you will be joining:
   Practice Name: _____
   Address: _____

3. If your practice is new to our community, please list the following:
   Practice Name: _____
   Address: _____
   Phone: _____ Fax: _____
   List all physicians in the practice / group: _____
   _____

4. If not joining a group practice, do you plan to establish or have you established an office near NKCH?
   Address: _____
   When will you open this office: _____

5. I plan to have the following office hours on or near the NKCH Campus:
   Specify Hours:_____
   Days of the Week:_____

North Kansas City Hospital (NKCH) maintains a streamlined, clinically approved product formulary of products and equipment that reflects our focus on quality, cost, and variation. We participate in a group purchasing organization, a purchasing collaborative and make decisions through our Value Analysis process. This process includes clinician stakeholders, all relevant data, and a transparent process. After appointment to the medical staff, the physician will be invited to a Perioperative Onboarding meeting which will include a discussion of the suppliers currently on contract in their practice area, the relationship with the GPO and Purchasing Collaborative and the Value Analysis Process.

Please return this form with copies of the following documents:

A. Current license to practice
B. Missouri BNDD Registration Certificate
C. DEA Registration Certificate (you will need a DEA registered in Missouri for appointment)
D. Proof of malpractice liability insurance coverage or eligibility, which indicates the effective date and amount. (Please note a minimum of $500,000 coverage is required for each occurrence.)
E. Curriculum Vitae (CV)

I agree to abide by the intended practice plan described in this pre-application form if I am granted Medical Staff membership at NKCH. I expressly agree that, in consideration for NKCH's willingness to review this intended practice plan and consider the information provided herein, I waive and release any claims, including but not limited to, any claim of entitlement to a hearing or appellate review, against NKCH, its Medical Staff and their officers, directors and agents, arising from a decision to not provide to me an application for membership on the Medical Staff. I expressly understand and agree that such a decision is an administrative and business decision which may be made by NKCH independent of any professional review action and that such a decision will not result in any report to the National Practitioner Data Bank or any other agency. I also agree that if I am offered an application and granted Medical Staff membership but fail to abide by this intended practice plan, I may be subject to an administrative determination that I cannot exercise my privileges at NKCH without resort to the peer review processes and without giving rise to any claim of any nature against NKCH, its Medical Staff and their officers, directors and agents. I understand that if I have a conflict of interest and, despite that fact, I am permitted to apply for membership on the NKCH Medical Staff, my admissions and utilization patterns may be monitored and I agree I may be subject to an administrative determination that I cannot exercise my privileges at NKCH if deemed appropriate by the NKCH without resort to the peer review processes and without giving rise to any claim of any nature against NKCH, its Medical Staff and their officers, directors and agents. I hereby attest that the information provided above is true and correct. I will immediately notify the NKCH Medical Staff Services office in writing of any changes to my hospital or institutional affiliations that may present a conflict as described in the Medical Staff Conflict of Interest Policy, including notification of the commencement of my employment by any hospital or hospital-owned entity. I certify that I meet the basic threshold criteria for membership on the Medical Staff of North Kansas City Hospital and request an application for appointment to the Medical Staff. I understand this is not an application for membership on the Medical Staff and I may not receive an application if it appears this pre-application form reveals that I do not meet the threshold requirements.

_____ _____

Signature Date