

**Application for Professional Staff Appointment**

**To the Credentialed Professional Staff of London Health Sciences Centre (LHSC)**

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| **DEMOGRAPHIC INFORMATION** |
| **Last Name:** | **First Name:** |
| **Birthdate (mm/dd/yyyy):** | **Birthplace:** | **Citizenship:** |
| **Email Address:** | **OHIP Billing Number:** |
| **Business Address:** | **Postal Code:** |
| **Phone Number/Extension:** |
| **Current Home Address:** | **Postal Code:** |
| **Phone Number/Extension:** |
| **Future Home Address –** *if home address will change due to relocation* | **Postal Code:** |
| **Phone Number:** |
| **PROFESSIONAL LIABILITY INFORMATION** |
| **Liability Membership Number:** | **If CMPA, type of** [**Work Code**](https://www.cmpa-acpm.ca/en/membership/fees-and-payment)**:** | **Province of Coverage:** |
| **CERTIFICATE OF REGISTRATION**  |
|  | **Registration Date** | **Registration Type** | **Registration Number** |
| **College of Physicians and Surgeons of Ontario (CPSO)** |  |  |  |
| **Royal College of Dental Surgeons of Ontario (RCDSO)** |  |  |  |
| **College of Midwives of Ontario (CMO)** |  |  |  |
| **College of Nurses of Ontario (CNO)** |  |  |  |
| **FELLOWSHIP CERTIFICATION** |
| **Royal College of Physicians and Surgeons of Canada** | **Specialty:** | **Date:** |
| **Royal College of Dentists of Canada (Specialty)** | **Specialty:** | **Date:** |
| **College of Family Physicians of Canada** |  | **Date:** |
| **PREMEDICAL EDUCATION** |
| **University** | **City** | **Degree** | **Date of Graduation** |
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| **MEDICAL/DENTIAL/MIDWIFERY/NURSING EDUCATION** |
| **University** | **City** | **Degree** | **Date of Graduation** |
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| **POSTGRADUATE ENDUCATION (Residency / Fellowships)** |
| **University** | **City** | **Degree** | **Date of Graduation** |
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| **ADDITIONAL DIPLOMAS / DISTINCTIONS** |
| **University** | **City** | **Degree** | **Date of Graduation** |
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| **APPOINTMENT REQUEST DETAILS** |
| **Department:** |  |
| **Division:**  |  |
| **Category applicant is applying for:*** Associate ***(use only for full-time clinical academic position or Midwifery applicants)***
* Term ***(provide specific departmental clinical need for a defined period of time)***
* Supportive ***(provide support to patient/family and act as liaison between MRP and patient)***
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| **HOSPITAL DECLARATION**  |
| ***Please place an “X” within the “Yes” / “No” column for each of the following questions*** | **YES** | **NO** |
| 1. In the past 12 months, has your **Certificate of Registration** to practice medicine, dentistry, midwifery, or nursing been revoked, suspended, voluntarily surrendered, or subject to probationary terms?

**If “Yes”, please give full details below:** |  |  |
| 2. In the past 12 months, have you maintained your **Membership** with the College of Physicians and Surgeons of Ontario (CPSO), Canadian Medical Protective Association (CMPA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Midwives of Ontario (CMO), Royal College of Dental Surgeons of Ontario (RCDSO), College of Family Physicians of Canada (CFPC), and/or College of Nurses of Ontario (where applicable) including payment of membership dues and will continue to maintain your membership/registration for the full duration that you hold hospital privileges?**If “NO”, please give full details below:** |  |  |
| 3. In the past 12 months, have you been subject to any pending or completed reprimand or disciplinary action, professional misconduct, competency investigations, or mid-term suspension by any College, hospital, or administrative agency related to your professional work?**If “YES”, please give full details below:** |  |  |
| 4. In the past 12 months, have you been charged with or convicted of a criminal offence? **If “YES”, please give full details below:** |  |  |
| 5. In the past 12 months, has any civil claim or suit for alleged malpractice resulted in payment by you, or on your behalf by the Canadian Medical Protective Association (CMPA) and/or any insurance company? **If “YES”, please give full details below:** |  |  |
| 6. Do you currently have any illness, physical disability, or substance dependence that impairs your ability to practice medicine, dentistry, or midwifery?   **If ‘YES’, please give full details below:** |  |  |
| 7. Are you involved in any business or research relationships for the purpose of personal profit/gain that may place you in a conflict situation as it relates to your LHSC and St. Joseph’s hospital appointment(s)? **If ‘YES’, please give full details below:** |  |  |
| **DECLARATION CONTINUED** | **YES** | **NO** |
| 8. **Learning Modules and N95 Fit Testing:** Once I have gained access, I will comply with all required eLearning as designated in [ME(MyEducation)](https://ilearn.lhsc.on.ca/Saba/Web/Cloud) under the heading Current Learning and I will ensure N95 Fit Testing compliance (where applicable).  *I understand that a failure to comply with the requirements noted above will result in a recommendation by the LHSC Medical Advisory Committee to the LHSC Board of Directors to not be re-appointed to the Credentialed Professional Staff effective with the next reappointment cycle.* |  |  |
| 9. Patient Chart Completion: I will ensure completion and ongoing compliance of all patient charts and any Health Information Management documentation assigned to me.  **NOTE**: Timely completion and authentication of clinical documentation is a requirement of the College of Physicians and Surgeons of Ontario (CPSO) and is an essential component of quality patient care.  |  |  |
| 10. Full compliance with LHSC hospital policies and best practices, including Influenza Vaccination policy and COVID-19 Vaccination Program is required. With regard to the Influenza vaccination, I understand that I am required to either attain the Influenza vaccine or complete the approved Influenza Vaccination Attestation Form by March 31st.I understand that a failure to comply may affect ongoing renewal of my appointment with LHSC. |  |  |
| 11. I will comply with the Hospital’s communicable diseases and surveillance policies and practices. |  |  |
| **APPLICANT ACKNOWLEDGEMENT – PLEASE READ CAREFULLY** |
| If appointed to the Professional Staff of London Health Sciences Centre (LHSC), I agree to have read and govern myself in accordance with the provisions and the requirements set out in the Public Hospitals Act of Ontario, as well as other relevant legislation, the Professional Staff By-Laws, Rules and Regulations, ethical guidelines, policies and procedures of the LHSC, as well as the Mission, Vision and Values of the hospitals. I will participate in quality and patient safety initiatives by conducting all necessary and appropriate activities for assessing and improving the effectiveness, efficiency and safety of care provided by the Hospital. I understand that I may be required to serve on committees or subcommittees as appointed by the Board or Medial Advisory Committee. I understand that I am required to provide the hospital with three (3) months’ prior written notice of intent to resign or otherwise limit my exercise of privileges. I understand that failure to maintain an academic appointment where such academic appointment is a condition of the Hospital appointment may result in privileges being restricted, suspended, revoked, or being denied reappointment. I agree to inform the Board of Directors of any changes in the type of practice I undertake or in my qualifications or in my legal status to practice my profession in Ontario. I certify that all information submitted by me in this application is true to my best knowledge and belief. I understand that the provision of false information is sufficient grounds for rejection of this application or cancellation of privileges already granted. I certify that the professional liability protection identified in this application will be maintained during the period of time that I am a member of the Professional Staff of LHSC.I am aware that if I do not fulfill my obligations as a member of the Professional Staff, any or all privileges will be subject to cancellation at any time at the discretion of the Board of Directors for LHSC.I confirm that I am applying for Professional Staff privileges at London Health Sciences Centre (LHSC) and I agree to the above and certify that all information submitted by me in this application is true to my best knowledge and belief. Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Proceed to next page: Authorization for Release of Information**

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| **AUTHORIZATION FOR RELEASE OF INFORMATION** |
| 1. I, **(PRINTED NAME)** acknowledge that I am making formal application for a Professional Staff appointment and privileges at London Health Sciences Centre (LHSC).1. I hereby consent to the inspection of all records and documents from any health care institution that may be material to an evaluation of my professional qualifications and competence to perform the clinical activities requested as well as to evaluate my moral and ethical qualifications for professional staff membership, by duly authorized representatives of the:
* Medical Affairs Department
* Department Head (or delegate) where appointment is being applied for
* Credentialing Committee
* The University of Western of Ontario (as necessary)
1. I hereby authorize any health care institution where I currently hold or have previously held medical/dental/midwifery/extended class nursing affiliation, to release any information, records, or documents concerning my professional competence, ethics, character and other relevant qualifications for professional staff appointment and clinical privileges to the duly authorized representatives, as listed above.
2. I understand that a copy of my resume and any other documents or information provided or disclosed to the Hospital by me or any other party as a result of the application for appointment to the Credentialed Professional Staff of the Hospital may be shared with the University of Western Ontario and St. Joseph’s Health Care London.

5. I hereby certify that all information submitted for this application is an accurate representation of the current level of my training, experience, capability and competence to practise with the clinical privileges requested. I fully understand and agree as a condition of making this application that any significant misrepresentation, misstatement in or omission from this application, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application. In the event that any appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery will result in summary dismissal from the ProfessionalStaff.6. I fully understand and agree that I, as an applicant for Professional Staff membership at LHSC, am responsible to provide adequate information for proper evaluation of my professional competence characteristics, ethics and other qualifications, and for resolving any doubts about such qualifications.7. I understand that my application will not be considered until all information contained therein has been verified and until all the required supporting documentation has been received by the Medical Affairs Department for LHSC.By signing below, I agree to the above “Authorization and Release”.Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)   |