
Saint Clare's Health System

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

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

Where? _____

For what percentage of your total hospital practice do you anticipate using the facilities at Saint Clare’s Hospital. _____

4. MILITARY EXPERIENCE

Please indicate which branch of the military you served in: _____

Please indicate the years of service in the military: _____

Please indicate which type of affiliation you had in the military as follows:

- Training Military Affiliation Affiliation at Military Hospital
- Other _____

The National Records Personnel Center requires the following information:

Social Security Number: _____ Date of Birth: _____

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**