HOSPITAL FORM - PHYSICIAN

Access this form via website at: **cca.hawaii.gov/pvl**

TO THE APPLICANT: Complete the *"Applicant"* section of this form. Send a form to each hospital where you have held, or applied for, privileges, consultation, teaching appointments or locum tenens positions or served in an internship or residency **during any part of the most recent 3 years preceding your application** for a physician's license in Hawaii. Your residency program director may complete this form in place of each hospital's administrator. If more than one form is needed, please duplicate both pages.

APPLICANT

Name (First, Middle)	(Last)	Social Security No.:	Birthdate:

Date Served/Applied:	Capacity Served or Applied for:	Name of Hospital/Residency Program

To: CHIEF OF STAFF, ADMINISTRATOR OF HOSPITAL OR RESIDENCY PROGRAM DIRECTOR

I am applying for a license to practice medicine and surgery in Hawaii. The Board requires this form be completed by the Chief of Staff or Administrator in each hospital where I have held, or applied for, privileges, consultation, teaching appointments or locum tenens positions or served in an internship or residency. For my residency program, the program director may complete this form. This request relates to a background investigation that must be completed prior to my being considered for a Hawaii license.

This is your authority to release any information, files, or records, favorable or otherwise, requested by the Hawaii Medical Board in connection with my application. Please complete the following questionnaire, SUPPLY COPIES OF INFORMATION IN YOUR RECORDS that would provide further information and **return the material directly to the address on the following page**.

Signature of Applicant ____________________ Date ____________

CHIEF OF STAFF or ADMINISTRATOR OF HOSPITAL

NOTE: This form will be used to evaluate the current and past conduct and competency of the applicant. Any adverse/derogatory information reported may, out of necessity, be shared with the applicant so that the applicant may respond to that information.

PLEASE COMPLETE SECTIONS "A" AND "C" or "B" AND "C" AS APPLICABLE

A. **POSTGRADUATE TRAINING:**

In the event the response to any of the questions numbered A.3. through A.7. is "YES", please file a typewritten or legible handwritten detailed explanation and provide copies of records from your files.

1. Is the applicant or has the applicant been engaged in postgraduate training in the program? ☐ YES ☐ NO
2. Briefly evaluate the applicant's competence, conduct and professionalism during his/her affiliation. ____________________
3. Has the applicant ever been subject to adverse or disciplinary actions (e.g. any remediation, restriction, removal from patient care, probation, suspension, termination, extra training requirement, etc.)? ☐ YES ☐ NO
4. Is any disciplinary or adverse action pending against the applicant? ☐ YES ☐ NO
5. Is the applicant presently being investigated? ☐ YES ☐ NO
6. Has the applicant withdrawn or resigned (voluntary or otherwise) from the program? ☐ YES ☐ NO
7. Has the applicant been issued a notice of contract termination, non-renewal or non-promotion? ☐ YES ☐ NO

B. **HOSPITAL PRIVILEGES:**

In the event the response to any of the questions numbered B.2. through B.6. is "YES", please file a typewritten or legible handwritten detailed explanation and provide copies of records from your files.

1. Were privileges extended to the applicant? ☐ YES ☐ NO

   Please describe the types of privileges: ____________________

   If "NO", please explain: ____________________

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Print Name of Applicant: ______________________________ Date: ______________

(Cont'd from page 1)

CHIEF OF STAFF or ADMINISTRATOR OF HOSPITAL

2. Has the applicant ever been subject to disciplinary or adverse actions (e.g. any remediation, proctorship, restriction, removal from patient care, probation, suspension, etc.)? .... ☐YES ☐NO
3. Is there any disciplinary or adverse action pending against the applicant? .... ☐YES ☐NO
4. Is the applicant presently being investigated? .... ☐YES ☐NO
5. Has the applicant ever been denied or withdrawn an application for privileges or membership, or has the applicant ever resigned, surrendered, been terminated or failed to renew privileges or membership? ..... ☐YES ☐NO
6. Has the applicant ever been issued a notice of non-renewal? .... ☐YES ☐NO

C. **SAFE PRACTICE COMMENTS:**

In the event the response to any of the questions below is "YES", please file a typewritten or legible handwritten detailed explanation and provided copies of records from your files.

1. Is there anything in your files which would call into question the applicant's ability to safely practice medicine? .... ☐YES ☐NO
2. Is there any derogatory or adverse information on file? .... ☐YES ☐NO

PLEASE SUPPLY ANY COPIES OF INFORMATION IN YOUR RECORDS THAT WOULD PROVIDE FURTHER INFORMATION AND SEND TO:

Hawaii Medical Board
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

CERTIFICATION OF CHIEF OF STAFF, ADMINISTRATOR OR PROGRAM DIRECTOR:

I certify that the statements, answers, and representations on this form and in documents attached are true and correct. I understand that this certification and any misrepresentation may constitute a violation of section 710-1017, Hawaii Revised Statutes.

______________________________ ______________
Signature of Chief of Staff, Administrator or Program Director Date

Print Name: ______________________________

Title: ______________________________

Hospital/Residency Program: ______________________________

Address: ______________________________

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Phone No.: ( ) ______________________________

HOSPITAL/PROGRAM SEAL
(If none, please so indicate.)

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.