Pre-Application Request Form

(ALL SPACES MUST BE COMPLETED)

Full Name of Applicant: ________________________ **NPI Number** ________________ **DEA #** ________

☐ MD ☐ DO ☐ DMD ☐ Other ____________ DOB: ________________ Gender ______

Home Mailing Address: ________________________________ Phone: ____________
Number and Street

________________ ________________ ________________ Fax: ____________
City *State* *Zip*

Applicant's Personal Email Address: ______________________ **Email Address to Send Online Application Link If other than Applicant:** ______________________ ***(Webview Link will be sent to email address noted)***

Professional/Medical School ________________ Degree __________ Dates: ________ ________
From – **M/Y** **To - M/Y**

Post Graduate Training

________ ________ ________________________ Dates: ________ ________
Type **Program** **Institution (please include street address and state)** **From – M/Y** **To – M/Y**

________ ________ ________________________ Dates: ________ ________
Type **Program** **Institution (please include street address and state)** **From – M/Y** **To – M/Y**

________ ________ ________________________ Dates: ________ ________
Type **Program** **Institution (please include street address and state)** **From – M/Y** **To – M/Y**

Any gaps in training must be explained on a separate sheet of paper.

Practice/Group Joining : ________________________ Anticipated Start Date: __________

For Allied Health only - Sponsoring Physician: ________________________

Practice Address: ________________ ________________ ________________ ________________
Number and Street **City** **State** **Zip**

Practice Phone: ________________ Fax: ________________ Practice: Solo ☐ Group ☐

☐ My residence is/will be located in Lexington ☐ My residence is/will be located within ______ miles of Lexington

Certified by American Board of ________________________ Expiration Date: ______

If not board certified, provide explanation/board eligibility date ________________________

Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (e.g. Medicare, Medicaid)? Yes ☐ No ☐

Please indicate the specialty(s) in which you are requesting appointment. ________________________

I am applying for appointment at:

**Baptist-Physicians' Surgery Center (BPSC) **(appointment at BPSC requires privileges at Baptist Health Lexington)	☐	Bluegrass Endoscopy **(BGE)**	☐
UK Healthcare Good Samaritan Hospital (SAM)	☐	CHI Saint Joseph Health:	
Baptist Health Lexington (requires backup coverage)	☐	St. Joseph Berea **(SJB)**	☐
		St. Joseph East **(SJE)***	☐
Lexington Surgery Center (LSC)	☐	St. Joseph Hospital **(SJH)** *	☐
Baptist Health Surgery Center (former KSC)	☐	St. Joseph Mt. Sterling **(SJMS)**	☐

(for office use only---- Facilities please initial date for approval)

Primary Hospital where I hold admitting privileges ________________ **N/A ☐ (Allied Health)***

****Commonwealth Credentialing processes Allied Health applicants for SJB/SJE/SJH/SJMS only; AHPs requesting privileges at any of the other facilities must apply directly with that facility.***

By completion of this pre-application I understand that this form will be reviewed by the facility(s) indicated above and if all criteria is met and no Exclusive Contracts are in place for my requested privileges then I will be sent an initial appointment application. I understand that completing this form will in no way obligate the facility(s) at which I am applying for privileges to afford me medical staff membership or privileges.

I hereby acknowledge that in the event this pre-application is denied, I will not receive an application for appointment. I further acknowledge and agree that denial is not a professional review action and does not entitle me to any fair hearing or review rights under the facility(s) Bylaws, nor is it considered to be reportable to the National Practitioner Data Bank.I also certify that to the best of my knowledge the information above is complete and accurate and acknowledge that any omission or misrepresentation shall constitute sufficient cause for denial of my request for an application for appointment.