

Chinese Hospital  
Medical Staff Services  
845 Jackson Street, SF, CA 94133  
Tel: 415/677-2483  
Fax: 415/677-2439

## REQUEST FOR MEDICAL STAFF MEMBERSHIP/PRIVILEGES APPLICATION

PHYSICIAN NAME: \_\_\_\_\_ DATE OF REQUEST: \_\_\_\_\_

SPECIALTY: \_\_\_\_\_ OFFICE TELEPHONE: \_\_\_\_\_

CURRENT/MAILING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

### PLEASE ANSWER THE FOLLOWING STATEMENTS

1. I have a current license to practice medicine in the state of California. \_\_\_\_\_ Yes \_\_\_\_\_ No
2. I have a current federal DEA registration (Exceptions- Pathologists). \_\_\_\_\_ Yes \_\_\_\_\_ No
3. I have actively admitted, care for or participated in the hospital care of patients in an accredited acute care hospital for at least two of the past five years. \_\_\_\_\_ Yes \_\_\_\_\_ No
4. I have professional medical liability coverage as an independent provider, at least in the amount of \$1 million per claim/ \$3 million annual aggregate. \_\_\_\_\_ Yes \_\_\_\_\_ No
5. I plan to have an office or residence within reasonable distance of the hospital to allow for continuous care of hospitalized patients. \_\_\_\_\_ Yes \_\_\_\_\_ No

Having met the prerequisites for application to the Medical Staff of Chinese Hospital, I request an application and clinical privileges for the following specialty: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Physician