LAMONT HEALTH CARE CENTRE
5216 – 53 Street, PO Box 479
Lamont, Alberta TOB 2R0
Phone: 780-895-2211 FAX: 780-895-7305

APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF & REQUEST FOR PRIVILEGES

Name in full _____ Date _____

Office/Professional Address _____

_____

_____ Telephone _____

Residence Address _____

_____ Telephone_____

E-Mail _____ Cell Number_____

Place and Date of Birth _____ Citizenship _____

_____

Pre-Medical Education _____ Degree _____ Date _____

Medical Education:

University _____ Degree _____ Date _____

Internship: Hospital _____ Date _____

Address _____

Current Licensure:

Province of _____ Date _____

Registration Number _____

Previous Licensure:

Province of _____ Date _____

Registration Number _____

Do you hold the Licentiate of the Medical Council of Canada (LMCC) Registration YES ☐ NO ☐

LMCC Registration Number _____ Year Obtained _____

GRADUATE TRAINING FOLLOWING INTERNSHIP INSTITUTION (Attach copies of resumé, certificates, etc.)

Residencies _____ Date _____

_____ Date _____

or

Fellowships/Certification(s)_____ Date _____

_____ Date _____

Specialty (Specialties) _____ Date _____

_____ Date _____

Post-Graduate Fellowships_____ Date _____

_____ Date _____

Teaching Appointments _____ Date _____

_____ Date _____

Other _____ Date _____

_____ Date _____

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Membership on Other Hospital Staffs (Past & Present):

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

Membership in Medical Societies:

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

Current Professional Liability Insurance (Attach photocopy)

Company or Association _____ Policy Number _____
Effective Date of last Renewal _____

Please indicate your requested privileges:

Admitting	YES	NO
Full Admitting	☐	☐
On-Call Coverage Only	☐	☐
General Medicine & Pediatrics	☐	☐
Specialty (please specify)		

_____
_____

_____

Non-Admitting	YES	NO
Non-Admitting	☐	☐
Consults Only	☐	☐
Surgical Assist Only	☐	☐
Other (please specify)		

_____
_____
_____

Comments/Limitations to Privileges _____

_____
_____

What Medical Staff Appointment Category are you requesting:

☐ ACTIVE ☐ COURTESY
☐ TEMPORARY ☐ VISITING CONSULTANT
☐ OTHER (Specify) _____

Anticipated Date of Commencement _____
(Please DO NOT use "ASAP" for Date of Commencement)

If applying for Temporary Appointment indicate End Date _____

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'FITNESS TO PRACTICE'

- Are there any claims (whether settled or awaiting judgement) relative to your practice, based upon or related to allegations of professional negligence or misconduct? YES ☐ NO ☐

  If YES, please explain: _____
  _____

- Are there or have any limitations been imposed on your ability to practice by any employer, hospital, professional association or health or licensing authority? YES ☐ NO ☐

  If YES, please explain: _____
  _____

- Are there any prior decisions by any employer, hospital, professional association or health or licensing authority to deny, revoke, suspend or limit a license or right to practice? YES ☐ NO ☐

  If YES, please explain: _____
  _____

- Are there any physical or mental conditions, including any substance abuse related illness, which could reflect your ability to safely and competently exercise the Privileges request? YES ☐ NO ☐

  If YES, please explain: _____
  _____

- Are there any potential conflicts to fulfilment of your duties as a member of the Medical Staff?
  YES ☐ NO ☐

  If YES, please explain: _____
  _____

- Would you be willing to undergo a complete medical examination prior to appointment?
  YES ☐ NO ☐

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REFERENCES: Please name three (3) references who may be contacted concerning your application, including the CEO/Executive Director of last Health Care Facility.

Name – CEO/Executive Director of last Health Facility _____

Facility Name & Address _____ Phone _____

_____ Postal Code _____

Name _____ Phone _____

Address _____ Postal Code _____

Name _____ Phone _____

Address _____ Postal Code _____

Name _____ Phone _____

Address _____ Postal Code _____

I HAVE READ THE MEDICAL STAFF BYLAWS, RULES AND REGULATIONS AND AGREE TO ABIDE BY THESE BYLAWS AND REGULATIONS.

Signature _____ Date _____

APPROVED FOR APPOINTMENT TO THE _____ MEDICAL STAFF,
LAMONT HEALTH CARE CENTRE

Recommended Privileges _____

Date _____ _____ _____
President, Medical Staff Secretary, Medical Staff

APPROVED FOR APPOINTMENT TO THE _____ MEDICAL STAFF,
LAMONT HEALTH CARE CENTRE AND PRIVILEGES IN ACCORDANCE WITH

_____

_____

_____

Date _____ _____ _____
Chairman, Board of Management Secretary, Board of Management