NewYork-Presbyterian
Brooklyn Methodist Hospital

MEDICAL BOARD
506 Sixth Street
Brooklyn, NY 11215
Phone: 718-780-5110 Fax: 718-780-3222

REQUEST FOR APPLICATION

Date: _____ Specialty: _____

Name in Full: _____

Date of Birth: _____ S.S.# _____ Gender: Male ( ) Female ( )

Office Address: _____

City: _____ State: _____ Zip Code: _____

Office Telephone: (_____) _____ Email Address:_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: (_____) _____ Cell Phone: _(_____)_____

REQUIRED INFORMATION

1. Have you actively practiced in an accredited hospital as a practitioner or resident for at least 36 of the past 42 months? **YES ( ) NO ( )**

2. Do you have a valid license to practice in some jurisdiction? **YES ( ) NO ( )**
   State: _____ **License #:** _____

3. Do you currently have or have you applied for professional liability insurance for $1,300,000 per claim and $3,900,000 in aggregate as well as EXCESS insurance coverage? **YES ( ) NO ( )**

I certify that the information contained in this application is correct and complete to the best of my knowledge and belief. I realize that misrepresentation of facts called for on this application will be cause for rejection of this application and that approval of my credentialing is contingent upon passing medical, physical, drug screening and background checks, verification of references and other information furnished as part of my application for medical staff privileges, and a criminal record review, and authorize the Hospital to perform such checks, verifications and reviews as may reasonably have a bearing on my qualifications for appointment on the medical staff.

Name: _____ _____
(Please Print) (Date)

Name:_____
(Please Sign)