

GOLF SURGICAL CENTER

Request for Medical Staff Application

We appreciate your interest in joining our Medical Staff. Prior to receiving a complete enrollment packet we will require that you complete the information below.

Once completed and returned in the enclosed envelope, our Executive Committee will make the determination to forward you an enrollment packet.

First Name	Last Name	Degree	Specialty
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Home Address	Street	City	State	Zip
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Home Telephone	Cellular Phone Number	Long Range Pager
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Office Address	Street	City	State	Zip
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Office Telephone	Office Fax	Email Address
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PROFESSIONAL LIABILITY INSURANCE CARRIER - WHEN JOINING GOLF SURGICAL CENTER

Carrier: _____

Address: _____
Street City State Zip

Policy Number: _____ Original Effective Date : _____ Exp. Date: _____
mm/dd/yy mm/dd/yy

GOLF SURGICAL CENTER

Request for Medical Staff Application

Continued

First Name	Last Name	Title	Specialty
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HOSPITAL MEMBERSHIP – CURRENT AND PENDING

Please provide the complete name of the Department Chairman and his/her FAX # for EACH hospital listed.

A. Primary Hospital _____

Department Chairman _____ FAX # _____
First Name Last Name Degree

B. Other Hospital _____

Department Chairman _____ FAX # _____
First Name Last Name Degree

C. Other Hospital _____

Department Chairman _____ FAX # _____
First Name Last Name Degree

Signature of Applicant

Date

Medical Director

Date

Licensed Physician of Same Specialty

Date

Chairman, Executive Committee

Date