SOUTHWEST SURGICAL CENTER

Pre-Application Checklist

Applicant Full Name (PRINTED): _____

Credentials: ☐ DO ☐ MD ☐ CAA ☐ CRNA

☐ NP Surgery ☐ PA Surgery ☐ RNFA ☐ STFA

Cell Phone (with area code): _____ Email: _____

Date of Birth (mm-dd-yyyy): _____ Michigan License Number: _____

Anticipated Start Date (mm-dd-yyyy): _____

Specialty: ☐ Anesthesia ☐ ENT ☐ General ☐ Hand ☐ Orthopedics

☐ Pain ☐ Plastics ☐ Podiatry ☐ Other _____

Is there a physician in your practice who already has the same/similar privileges at Southwest Surgical Center?

☐ Yes ☐ No If yes, please provide name so that we may mirror your privileges: _____

To receive an application packet, the candidate must meet the following criteria:	**Yes**	**No**
I am a graduate of an approved School of Medicine, Osteopathy, Podiatry	☐	☐
I am a graduate of an accredited residency program	☐	☐
I am currently licensed in the State of Michigan.	☐	☐
I am currently: Board Certified Board Eligible		
I have active medical staff privileges at an acute care facility within twenty-five miles of Southwest Surgical Center	☐	☐
I am eligible to participate with Medicare / Medicaid	☐	☐
I am free from suspensions of licensure, DEA certification, board certification, or clinical privileges	☐	☐

Applicant Full Name (PRINTED): _____

I have answered the above questions honestly to the best of my ability. I hereby stipulate that I meet the pre-application Criteria set forth in the Southwest Surgical Center Medical Staff Manual.

Applicant Signature _____ Date _____

The applicant meets the minimum threshold criteria for application to the Southwest Surgical Center. The applicant is approved to begin the full application process.

Operations Committee Member Signature _____ Date _____

Additional Informtion:

Credentialing Contact / Delegated User Name: _____

Address: _____ City: _____State: _____ Zip: _____

Phone (with area code): _____ Fax: _____

Email: _____