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Approved	Date
BPSC	
Baptist Health Lexington	
LSC	
KSC	
SAM	
SJE	
SJH	
SJ-Mount Sterling	

Pre-Application Request Form

(ALL SPACES MUST BE COMPLETED)

Full Name of Applicant: _____

☐ MD ☐ DO ☐ DMD ☐ Other _____ DOB: _____ Gender _____

Current Mailing Address: _____ Phone: _____
Number and Street

_____ _____ _____ Fax: _____
City State Zip

Email Address: _____

Professional/Medical School _____ Degree _____ Dates: _____ _____
From To

Post Graduate _____ _____ _____ Dates: _____ _____
Type Program Institution/State From To

_____ _____ _____ Dates: _____ _____
Type Program Institution/State From To

_____ _____ _____ Dates: _____ _____
Type Program Institution/State From To

Any gaps in training must be explained on a separate sheet of paper.

Practice/Group Joining: _____ Anticipated Start Date: _____

Allied Health - Sponsoring Physician: _____

Practice Address: _____ _____ _____ _____
Number and Street City State Zip

Practice Phone: _____ Fax: _____ Practice: Solo ☐ Group ☐

☐ My practice is/will be located in Lexington ☐ My practice is/will be located within _____ miles of Lexington

☐ My residence is/will be located in Lexington ☐ My residence is/will be located within _____ miles of Lexington

Please mail my Initial Application to my: ☐ Current Address ☐ Practice Address ☐ Other Address (separate page)

Certified by American Board of _____ Expiration Date: _____

If not board certified, provide explanation/board eligibility date _____

Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (e.g. Medicare, Medicaid)? Yes ☐ No ☐

Please indicate the specialty(s) in which you are requesting appointment. _____ I am applying for appointment at:

**Baptist-Physicians' Surgery Center (BPSC) ☐
**(appointment at BPSC requires privileges at Baptist Health Lexington)

Baptist Health Lexington ☐
(requires backup coverage)

Lexington Surgery Center (LSC) ☐

Kentucky Surgery Center (KSC) ☐

Saint Joseph Mount Sterling ☐

UK Healthcare Good Samaritan Hospital (SAM) ☐

KentuckyOne Health:

St. Joseph East **(SJE)** ☐

Saint Joseph Hospital **(SJH)** ☐

Primary Hospital where I hold admitting privileges _____ N/A ☐ (Allied Health)

By completion of this pre-application I understand that this form will be reviewed by the facility(s) indicated above and if all criteria is met and no Exclusive Contracts are in place for my requested privileges then I will be sent an initial appointment application. I understand that completing this form will in no way obligate the facility(s) at which I am applying for privileges to afford me medical staff membership or privileges.

I hereby acknowledge that in the event this pre-application is denied, I will not receive an application for appointment. I further acknowledge and agree that denial is not a professional review action and does not entitle me to any fair hearing or review rights under the facility(s) Bylaws, nor is it considered to be reportable to the National Practitioner Data Bank.

I also certify that to the best of my knowledge the information above is complete and accurate and acknowledge that any omission or misrepresentation shall constitute sufficient cause for denial of my request for an application for appointment.