



SIR LESTER BIRD MEDICAL CENTRE

MICHAEL'S MOUNT, ST. JOHN'S, ANTIGUA · TEL: +1 (268) 484-2700

Internship Programme — Clinical Privilege Application Form

★ INSTRUCTIONS

This form must be typed or written clearly in black ink. Attach a clearly labelled continuation sheet if additional space is needed. **All sections must be completed.** If a section does not apply, check the "Does Not Apply" box where provided. A Curriculum Vitae alone is **not** an acceptable substitute for this application.

★ INTERN CREDENTIALING REQUIREMENTS CHECKLIST

Complete all fields. Attach all required documents before submission. All sections are mandatory.

- ☐ **Letter of Application** — A formal letter expressing your intent to join the Internship Programme.
- ☐ **Completed SLBMC Clinical Privilege Form** — This application fully completed, signed, and dated in all required sections.
- ☐ **Detailed Résumé / Curriculum Vitae** — Chronological history beginning with professional education.
- ☐ **Three (3) Reference Letters** — Written references from individuals who have recently observed your work, medical school professors, etc. *Not older than 3 months.*
- ☐ **Certified Copies of Medical School Certificates** — Official certified copies of the originals. Any documents not in English must include an official certified translation.
- ☐ **Academic Transcript** — Official academic record sent directly from your medical school or university or a duly notarised copy.
- ☐ **Copy of Passport Bio Page** — Clear, legible copy of the biographical data page of your valid passport.
- ☐ **One (1) Passport-Size Photograph** — Recent, colour photograph with a plain background.
- ☐ **Immunisation Records** — Up-to-date vaccination records of all applicable immunisations.
- ☐ **Recent Police Record / Certificate of Good Character** — *Not older than 3 months.*
- ☐ **CAMC Part 1 or Equivalent** — CAMC Part 1, USMLE Steps 1 & 2, PLAB Parts 1 & 2, or other recognised equivalent examination results.
- ☐ **Current Medical Licence** — Valid, unexpired professional licence to practise medicine (can apply once selected for the programme).

FOR COMMITTEE USE ONLY

PHYSICIAN'S NAME

APPLICATION REVIEW DATE



I. PRACTITIONER'S INFORMATION

SURNAME <i>(incl. Jr., III.) *</i>	FIRST NAME *	MIDDLE NAME	PROFESSIONAL TITLE(S) *
OTHER NAME(S) AS THEY APPEAR ON LICENCES OR ACADEMIC RECORDS			
STREET ADDRESS *		CITY *	
COUNTRY *	STATE / PARISH / PROVINCE		POST OFFICE BOX
HOME TELEPHONE *	MOBILE PHONE *		E-MAIL ADDRESS *
DATE OF BIRTH *	PLACE OF BIRTH (CITY, COUNTRY) *	NATIONALITY *	GENDER *
SOCIAL SECURITY / NATIONAL ID NUMBER		MEDICAL BENEFITS SCHEME (MBS) NUMBER	

II. PROFESSIONAL LICENCES & REGISTRATIONS

PRIMARY LICENCE — COUNTRY OF ISSUE:

LICENCE / REGISTRATION NUMBER *	DATE ISSUED *	DATE OF EXPIRATION *

OTHER COUNTRY / JURISDICTION (IF APPLICABLE)

COUNTRY	LICENCE NUMBER	YEAR OBTAINED
EXPIRY YEAR		

III. PRE-DOCTORAL EDUCATION (BACHELOR'S DEGREE)

COLLEGE OR UNIVERSITY	TITLE / DEGREE RECEIVED	DATE OF GRADUATION
ADDRESS	STATE / POSTAL CODE / PARISH	COUNTRY



IV. MEDICAL EDUCATION

MEDICAL SCHOOL — PRIMARY

SCHOOL OF MEDICINE *

TITLE / DEGREE OBTAINED *

DATE OF GRADUATION *

ADDRESS

STATE / POSTAL CODE / PARISH

COUNTRY

MEDICAL SCHOOL — ADDITIONAL (IF APPLICABLE)

SCHOOL OF MEDICINE

TITLE / DEGREE OBTAINED

DATE OF GRADUATION

ADDRESS

STATE / POSTAL CODE / PARISH

COUNTRY

V. ADDITIONAL MEDICAL EDUCATION / TRAINING

List any postgraduate training, fellowships, or other formal programmes completed.

INSTITUTION

CITY

PROGRAMME / STUDY UNDERTAKEN

DIRECTOR OF FACULTY

PERIOD ATTENDED (MM/YYYY – MM/YYYY)

VI. LIFE SUPPORT & OTHER CERTIFICATIONS

Attach copies of all applicable certificates. Leave fields blank if not applicable.

BLS — DATE

BLS — EXPIRATION

ACLS — DATE

ACLS — EXPIRATION

PALS — DATE

PALS — EXPIRATION

ATLS — DATE

ATLS — EXPIRATION

OTHER CERTIFICATION (E.G. FLUOROSCOPY, X-RAY)

DATE / EXPIRATION

VII. EMPLOYMENT HISTORY

List work placements not covered by your education. Include all chronological gaps.

POSITION 1

INSTITUTION / COMPANY

CONTACT PERSON

TELEPHONE

ADDRESS

CITY

FROM (MM/YYYY)

TO (MM/YYYY)

**VII. EMPLOYMENT HISTORY** *(continued)***POSITION 2**

INSTITUTION / COMPANY

CONTACT PERSON

TELEPHONE

ADDRESS

CITY

FROM (MM/YYYY)

TO (MM/YYYY)

VIII. PROFESSIONAL REFERENCES

Provide three written references from individuals who have recently observed your work, medical school professors, etc. References must not include parents, current or future partners, or associated persons.

REFERENCE 1

FULL NAME *

TITLE / POSITION *

TELEPHONE *

ADDRESS

STATE / POSTAL CODE / PARISH

COUNTRY

REFERENCE 2

FULL NAME *

TITLE / POSITION *

TELEPHONE *

ADDRESS

STATE / POSTAL CODE / PARISH

COUNTRY

REFERENCE 3

FULL NAME *

TITLE / POSITION *

TELEPHONE *

ADDRESS

STATE / POSTAL CODE / PARISH

COUNTRY

IX. PROFESSIONAL DISCLOSURES

Answer each question truthfully. If the answer to any question is **Yes**, attach a detailed written explanation on a separate, signed and dated sheet referencing the question number.

- | | |
|---|--|
| 1. Have you ever participated in or been affiliated with a Prepaid Health Plan or Managed Care Organisation? | ☐ Yes ☐ No |
| 2. Are you familiar with the use of CPT-4 and ICD-10 coding systems? | ☐ Yes ☐ No |
| 3. Have you ever been subject to disciplinary action by, or do you currently have proceedings pending before, any Medical Board, Professional Association, or regulatory authority? | ☐ Yes ☐ No |
| 4. Have any of your medical or professional licences ever been denied, limited, suspended, or revoked in any jurisdiction? | ☐ Yes ☐ No |
| 5. Have you ever been suspended, sanctioned, excluded, or restricted from participating in any public or private health insurance programme? | ☐ Yes ☐ No |
| 6. Have you ever been the subject of a formal investigation by any public or private health insurance programme? | ☐ Yes ☐ No |
| 7. Has your authority to prescribe, dispense, or handle controlled substances (narcotics) ever been limited, suspended, or revoked? | ☐ Yes ☐ No |
| 8. Have you ever been charged with, or convicted of, any criminal offence (excluding minor traffic violations)? | ☐ Yes ☐ No |
| 9. Have you ever been named as a defendant in a malpractice claim or lawsuit, or do you have any unresolved judgements or open claims currently against you? | ☐ Yes ☐ No |



X. APPLICATIONS IN PROGRESS

NAME & ADDRESS OF HOSPITAL / INSTITUTION	DATE OF APPLICATION
NAME & ADDRESS OF HOSPITAL / INSTITUTION	DATE OF APPLICATION

XI. HEALTH STATUS DECLARATION

If any answer is **Yes**, provide detailed information on a separate sheet, including a description of any reasonable accommodation that could facilitate performance of clinical duties without risk.

1. Do you currently have any physical or mental health condition — including dependence on alcohol or any substance — that affects, or is reasonably expected to progress within the next two (2) years to the point of affecting, your ability to perform the requested clinical privileges or medical duties? ☐ Yes ☐ No
2. Are you currently taking any medication or receiving treatment for a condition that could impair your medical performance or professional obligations if discontinued? ☐ Yes ☐ No
3. Have you been hospitalised or received inpatient / institutional care for a physical or mental health condition within the past five (5) years? ☐ Yes ☐ No

DATE OF MOST RECENT PHYSICAL EXAMINATION

NAME OF EXAMINING PHYSICIAN

XII. CERTIFICATION & SIGNATURE

I hereby certify that all information provided in this application is complete, accurate, and current to the best of my knowledge and belief. I acknowledge that any omission, misrepresentation, or falsification constitutes grounds for denial of the internship application. A photocopy or electronic copy of this signed application shall have the same force and effect as the original. I have reviewed this information up to the date indicated below.

FULL PRINTED NAME *

SIGNATURE *

DATE *

Note: Rubber stamp signatures are not accepted. The signature must be that of the applying practitioner. Applications with incomplete or missing signatures will not be processed.