



COTH

Council of Teaching Hospitals and Health Systems

APPLICATION FOR COTH MEMBERSHIP

Please check the option, as explained in the General Information and COTH Membership Criteria document, to which you wish to apply for full COTH membership:

- Check here if you are applying for (A) individual hospital membership _____
- Check here if you are applying for (B) common hospital/system membership _____
- Check here if you are applying for (C) multiple hospital/system membership _____

Please complete all sections of this application and return the completed application and appropriate supporting documents to the address on the last page of this application.

Hospital Information

Hospital Name: _____

Hospital Address: _____

Hospital Address: _____

City: _____ State: _____ Zip: _____

Main Hospital Telephone Number: _____ URL: _____

Hospital Chief Executive Officer (CEO): _____

CEO's Title: _____

CEO's Telephone Number: _____ FAX: _____

CEO's E-mail: _____

System Name (for Options B and C only): _____

System Address: _____

System Address: _____

City: _____ State: _____ Zip: _____

System CEO: _____

System CEO's Title: _____

System CEO's Telephone Number: _____ FAX: _____

System CEO's E mail: _____



I. Hospital Operating Data (for the most recently completed fiscal year: FY _____)

Patient Service Data

Licensed Bed Capacity
(Adult & Pediatric,
excluding newborn): _____
Average Daily Census: _____
Total Live Births: _____

Admissions: _____
Emergency Room Visits: _____
Outpatient or Clinic Visits: _____

Financial Data

Total Operating Expenses: \$ _____
Total Payroll Expenses: \$ _____

Hospital Expenses for
Housestaff Stipends &
Fringe Benefits: \$ _____
Hospital Expenses for
Supervising Faculty: \$ _____

C. Staffing Data

Number of Full Time Personnel: _____
Number of Part Time Personnel: _____

Number of Physicians Appointed to the Hospital's Active Medical Staff: _____

Number of Physicians with Medical School Faculty Appointments: _____

Please list all hospital clinical services with full-time salaried Chiefs of Service:

Does the hospital have a full-time salaried Director of Medical Education: ____ Yes ____ No
If Yes, please provide name: _____

List here any additional staffing information pertinent to the hospital's medical education curricula: _____



II. Medical Education Data

A. Undergraduate Medical Education

Please complete the following information on your hospital’s participation in undergraduate medical education during the most recently completed academic year:

Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	_____	_____	_____
Surgery	_____	_____	_____
Ob-Gyn	_____	_____	_____
Pediatrics	_____	_____	_____
Family Practice	_____	_____	_____
Psychiatry	_____	_____	_____
Other	_____	_____	_____

B. Graduate Medical Education

Please complete the following information on your hospital’s participation in graduate medical education reporting only full-time equivalent positions offered and filled. If your hospital participates in combined programs, indicate only FTE positions and individuals assigned to your institution.

Residency Program	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled Foreign Grads	Date of Initial Accreditation of the Program
Medicine	_____	_____	_____	_____
Surgery	_____	_____	_____	_____
Ob-Gyn	_____	_____	_____	_____
Pediatrics	_____	_____	_____	_____
Family Practice	_____	_____	_____	_____
Psychiatry	_____	_____	_____	_____
All Other	_____	_____	_____	_____



III. Supplementary Information

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Sections I – III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital’s organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

IV. Supporting Documents

- A. When returning the completed application, please enclose a copy of the hospital’s current medical school affiliation agreement.
- B. A letter of confirmation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role of the applicant hospital in the school’s educational programs.

Name of Affiliated Medical School: _____

Dean of Affiliated Medical School: _____

Information on this application submitted by: (Name) _____

(Title) _____

(Phone) _____

Signature of hospital’s Chief Executive Officer

Date

Please complete all sections of this application and return the completed application and appropriate supporting documents to:

Ephonia M. Green
Program Administrator, COTH Membership Services
AAMC
Division of Health Care Affairs
2450 N Street, N.W.
Washington, D.C. 20037

Please direct any questions concerning this application to Ephonia Green at 202.828.0490 or egreen@aamc.org.