APPLICATION FOR COTH MEMBERSHIP

GENERAL INFORMATION AND COTH MEMBERSHIP CRITERIA

Membership in COTH is limited to organizations having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education (LCME). Typically, these organizations must sponsor, or participate significantly in, at least four approved, active residency programs. At least two of the approved residency programs should be in medicine, surgery, obstetrics/gynecology, pediatrics, family practice, or psychiatry. Membership applications to COTH are reviewed by the COTH Administrative Board, which serves as the AAMC’s membership committee for hospital participation. Under certain circumstances, and for certain types of hospitals such as children’s, VA, military and specialty hospitals, the COTH Administrative Board may approve full membership for hospitals and health systems that do not meet the full membership requirements.

Institutions that do not meet full membership criteria may be approved for corresponding COTH membership. Corresponding members are eligible to attend all open AAMC meetings and enjoy many of the privileges of full members, but are not eligible to participate in AAMC committees, the COTH Administrative Board, the AAMC Board of Directors, the AAMC Assembly or other AAMC governance structures. Organizations meeting full membership criteria, or who are offered full membership in certain situations, will not be considered for corresponding membership.

Membership Options

(A) Individual Teaching Hospital Membership - This option is intended for freestanding teaching hospitals that wish to join as individual teaching hospitals (even though they may be members of a system).

(B) Common Teaching Hospital/Health System Membership - This option is intended for non-federal COTH members who are the only COTH eligible hospital within a health system, or health systems which have multiple COTH-eligible hospitals but where (1) it has been determined that all COTH eligible hospitals do not wish to be members of COTH, or (2) the COTH eligible hospitals prefer to retain their individual hospital membership status. This option provides the system with complimentary COTH membership (as part of the hospital’s membership), forming a single member with the same dues structure as Option (A) and a single governance vote.

(C) Multiple Teaching Hospital/Health System Membership - This membership option is designed for systems where all non-federal COTH eligible hospitals within a health system are currently COTH members or wish to be COTH members, though they will still retain the privileges and benefits of individual members. Multiple teaching hospital/health system membership also entitles the system to complimentary membership by virtue of its hospitals’ memberships. A multiple teaching hospital/health system member will have as many governance votes as the number of its COTH member hospitals.

Corresponding COTH Membership - Institutions that apply for membership options A, B or C but do not meet the criteria for full membership but fulfill a crucial educational and service role in the community may be considered for corresponding COTH membership under Option A.
Please complete all sections of this application and return the completed application and appropriate supporting documents to the address on the fifth page of this application.

I. Please check the membership option you are seeking, as explained on the previous page of this application. Check only one:

Option (A) individual hospital membership  _____________
Option (B) common hospital/system membership  _____________
Option (C) multiple hospital/system membership*  _____________

II. HOSPITAL INFORMATION

   Primary teaching hospital name** _______________________________________________________________
   Hospital address _____________________________________________________________________________
   Hospital address _____________________________________________________________________________
   City ________________________________________ State _______________ Zip_________________________
   Main hospital telephone number ________________________ URL ___________________________________
   **If applying for option B or C, please list primary teaching hospital.

III. HOSPITAL CEO

   CEO name _______________________________________________________________
   Telephone number ______________________ Fax ______________________________
   Email _______________________________________________________________

   CEO’s assistant’s name _______________________________________________________________
   Assistant’s telephone number ______________________ Fax ______________________________
   Assistant’s email _______________________________________________________________

*If you are applying for Option C membership, please use Appendix A to add additional hospitals.
Check here if you are not part of a system. Please skip to Section VI.

IV. SYSTEM INFORMATION

System name __________________________________________________________________________
System address __________________________________________________________________________
System address __________________________________________________________________________
City ____________________________ State _______________ Zip ________________
Main system telephone number ______________________   URL ______________________________

V. SYSTEM CEO

System name __________________________________________________________________________
Telephone number ______________________ Fax ________________________________
Email _________________________________________________________________________________

CEO’s Assistant’s name __________________________________________________________________
Assistant’s telephone number ______________________ Fax ______________________________
Assistant’s email __________________________________________________________________________

VI. HOSPITAL DATA (for the most recently completed fiscal year: FY________)

Medicare provider number ________________________
American Hospital Association (AHA) identification number ________________________________
Licensed bed capacity (adult & pediatric, excluding newborn) ___________________________
Average daily census ________________________
Total operating expenses $_____________________________
Total payroll expenses $_____________________________

VII. MEDICAL STAFFING

Number of Physicians Employed by the Hospital/Health System__________

Employed Physicians Are in the Following Specialties (please list) ______________________________________

Number of Physicians Appointed to the Hospital’s Active Medical Staff __________________________
Number of Physicians with Medical School Faculty Appointments _____________________________
Total Number of M.D.s with Admitting Privileges __________________________
VII. FACULTY PRACTICE PLAN (Check those answers that apply)

Are your clinical faculty physicians employed? Yes ____ No____

If yes, who are they employed by? (Check all that apply):

Faculty practice(s) ____ Hospital ____ University ____ System ____ Other ____

If you selected “Other” please state what entity ____________________________________________

VIII. FACULTY PRACTICE POSITIONS

Name of Faculty Practice Plan Administrative Leader __________________________________________

Telephone number __________________________ Email _________________________________________

Name of Faculty Practice Plan Physician Leader _____________________________________________

Telephone number __________________________ Email _________________________________________

IX. SELECT HOSPITAL POSITIONS

Name of Chief Financial Officer __________________________________________________________

Telephone number __________________________ Email _________________________________________

Name of Chief Compliance Officer ______________________________________________________

Telephone number __________________________ Email _________________________________________

Name of Chief Medical Officer _________________________________________________________

Telephone number __________________________ Email _________________________________________

X. MEDICAL EDUCATION DATA

Name of hospital’s Designated Institutional Official (DIO) as required by the ACGME (Accreditation Council for Graduate Medical Education) _________________________________________________

A. Undergraduate Medical Education

Please complete the following information on your hospital’s participation in undergraduate clinical clerkships during the most recently completed academic year. Check the medical student clerkships you offer or participate in:

Clinical Services Providing Clerkships

☐ Allergy and Immunology ☐ Nuclear Medicine ☐ Preventive Medicine
☐ Anesthesiology ☐ Obstetrics and Gynecology ☐ Psychiatry
☐ Colon and Rectal Surgery ☐ Ophthalmology ☐ Radiology-Diagnostic
☐ Dermatology ☐ Orthopaedic Surgery ☐ Radiation Oncology
☐ Emergency Medicine ☐ Otolaryngology ☐ Surgery
☐ Family Medicine ☐ Pathology-Anatomic and Clinical ☐ Thoracic Surgery
☐ Internal Medicine ☐ Pediatrics ☐ Urology
☐ Medical Genetics ☐ Physical Medicine and Rehabilitation ☐ Other, please list __________
☐ Neurology ☐ Plastic Surgery

☐ Other, please list __________
B. Graduate Medical Education
Please complete the following information on your hospital’s participation in graduate medical education.

Check the residency programs that you sponsor or participate in:

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<thead>
<tr>
<th>Residency Program</th>
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<tbody>
<tr>
<td>Allergy and Immunology</td>
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<td>Anesthesiology</td>
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<td>Colon and Rectal Surgery</td>
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<td>Pediatrics</td>
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<td>Pathology-Anatomic and Clinical Pediatrics</td>
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<td>Physical Medicine and Rehabilitation</td>
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<td>Plastic Surgery</td>
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<td>Radiology-Diagnostic</td>
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<td>Thoracic Surgery</td>
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<td>Urology</td>
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<td>Other, please list</td>
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XI. 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 prior sections 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.

XII. 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)________________________________________________

(Email) ________________________________________________

_____________________________________________________ __________________________________

Signature of Hospital or System Chief Executive Officer    Date

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

LaTonya Ford
COTH Membership Services
AAMC
655 K Street, NW, Suite 100,
Washington, DC, 20001-2399
lford@aamc.org

Please direct any questions concerning this application to LaTonya Ford at 202-828-0490 or lford@aamc.org.
*APPENDIX A*

This section is for those applying for Option C membership. Please list additional hospitals here.

I. INFORMATION OF FIRST ADDITIONAL HOSPITAL

First additional hospital name _________________________________________________________________
Hospital address __________________________________________________________________________
Hospital address __________________________________________________________________________
City ___________________________ State ___________ Zip____________________________
Main hospital telephone number _____________________ URL ______________________________________

II. HOSPITAL CEO OF FIRST ADDITIONAL HOSPITAL

First additional hospital CEO name___________________________________________________________
Telephone number __________________________ Fax ______________________________________________
Email __________________________________________________________________________________

CEO’s Assistant’s name__________________________________________________________________
Assistant’s telephone number___________________________ Fax ______________________________
Assistant’s email ______________________________________________________________________

I. INFORMATION OF SECOND ADDITIONAL HOSPITAL

Second additional hospital name _______________________________________________________________
Hospital address __________________________________________________________________________
Hospital address __________________________________________________________________________
City ___________________________ State ___________ Zip____________________________
Main hospital telephone number _____________________ URL ______________________________________

II. HOSPITAL CEO OF SECOND ADDITIONAL HOSPITAL

Second additional hospital CEO name___________________________________________________________
Telephone number __________________________ Fax ______________________________________________
Email __________________________________________________________________________________

CEO’s Assistant’s name__________________________________________________________________
Assistant’s telephone number___________________________ Fax ______________________________
Assistant’s email ______________________________________________________________________