AAMC
Tomorrow's Doctors, Tomorrow's Cures®

Academic Health System & Teaching Hospital Membership

APPLICATION FORM

GENERAL INFORMATION AND MEMBERSHIP CRITERIA

AAMC membership is limited to health systems and teaching hospitals 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 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 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 members who are the only eligible hospital within a health system, or health systems which have multiple eligible hospitals but where (1) it has been determined that all eligible hospitals do not wish to be members of the AAMC, or (2) the eligible hospitals prefer to retain their individual hospital membership status. This option provides the system with complimentary AAMC 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 AAMC eligible hospitals within a health system are currently AAMC members or wish to be AAMC 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 AAMC member hospitals.

Corresponding 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 AAMC membership under Option A.

Academic Health System & Teaching Hospital Membership

APPLICATION FORM

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

Residency Program

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

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 document with appropriate supporting materials via email to:

Mirtha Soto

Manager, Hospital & Health System Membership and Engagement

msoto@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 _____