

COUNCIL OF TEACHING HOSPITALS AND HEALTH SYSTEMS

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.

COTH

COUNCIL OF TEACHING HOSPITALS AND HEALTH SYSTEMS

APPLICATION FOR COTH MEMBERSHIP

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

CEO 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

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

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

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

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:

Christiane Mitchell
COTH Membership Services
AAMC
655 K Street, NW, Suite 100,
Washington, DC, 20001-2399
cmitchell@aamc.org

Please direct any questions concerning this application to Christiane Mitchell at 202-828-0490 or cmitchell@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 _____