



Application for Employment

Illinois

Copies of the following must be included in your packet:

- All State Medical Licensure**
- State Controlled Substance License**
- DEA Certificate**
- ACLS, ATLS, PALS, BLS etc**
- Driver's License**
- Color Photo - Clear and Current**
- Proof of CME - Past 3 Years**
- ECFMG - if applicable**
- Copy of Medical School Diploma**
- CV (current)**
- Board Certificate - if applicable**
- Recent TB Test Results**
- NPI Letter or Email**
- Birth Certificate**



Contact Information

Name: _____

Email Address: _____

Home Phone: _____

Office Phone: _____

Mobile Phone: _____

Pager & Pin: _____

Other Number: _____



Please List at least 5 peer references:

Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

Fax: _____

Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

Fax: _____

Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

Fax: _____

Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

Fax: _____

Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

Fax: _____



Immunity and Release

I understand and agree that I am in the process of applying as an Independent Contractor to staff contracts held by Emergency Staffing Solutions and that no agreement will be effective until signed by both Emergency Staffing Solutions and me nor will I have any contractual agreement with Emergency Staffing Solutions until that occurs.

I hereby confirm that the information contained in my application is complete and accurate. Material omissions or false statements may be grounds for Emergency Staffing Solutions disregarding this application or terminating my Independent Contractor status. I authorize Emergency Staffing Solutions to contact the references listed in this application and to conduct a customary investigation of my professional background and personal history, including contacting sources not listed by me. A photocopy of this authorization shall be as valid as the original.

I hereby release and hold harmless from and against any and all liability all representatives of Emergency Staffing Solutions and the Hospital(s) for their acts and communications performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. I also hereby release from any liability any individuals and organizations who provide information to Emergency Staffing Solutions and the Hospital(s) in good faith and without malice concerning my professional competence, ethics, character and other qualifications for employment, clinical privileges and staff appointments, and I hereby consent for the release of such information.

Signature

Printed Name

Date



Emergency Department Experience



Hospital Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Other Hospital/Practice Experience

(continued - if necessary)



Hospital/Practice Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital/Practice Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital/Practice Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital/Practice Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital/Practice Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital/Practice Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Physician's Authorization

I hereby authorize Emergency Staffing Solutions or any of its duly authorized administrators to accept on my behalf any assignment made by any individual who receives medical treatment from me at any facility contracted by Emergency Staffing Solutions of the amount payable to such individual under Part B or Title XVIII of the Social Security Act and to receive on my behalf any payments that may be made pursuant to such assignment. It is understood and agreed that the reasonable charge, which will serve as the basis for payments in accordance with the terms of such assignment, shall be the full charge for the service.

This authorization may be withdrawn at any time upon giving at least 30 days prior written notice to the administrator.

Physician's Signature

Printed Name

Date



Health Statement

I hereby declare that _____ is in good physical health, mentally and emotionally stable, further more, has no health impairments affecting the priveleges requested in his/her application to Emergency Staffing Solutions. This physician has not been hospitalized or institutionalized for any significant health problems during the past five years and is not receiving current therapy for any health problems.

****to be completed by a physician other than yourself****

Physician Signature

Printed Name

Date



Emergency Medicine Delineation

1 - I am familiar with this procedure/have performed and competent to perform

2 - I have not performed, but I have been trained; competent to perform in an emergency situation

3 - I have not performed, and I am not comfortable in performing in an emergency situation

1 2 3	Management of electrolyte disturbances	1 2 3	Treatment of diabetic ketocidosis
1 2 3	Suturing, including facial lacerations	1 2 3	Treatment of snakebite
1 2 3	Treatment of common poisonings	1 2 3	Routine x-rays for fracture
1 2 3	Management of pediatric emergencies	1 2 3	Anesthesia (IV conscious sedation)
1 2 3	Management of severe head injuries	1 2 3	Bladder Cath/Irrigation
1 2 3	Treatment of hypovolemic shock	1 2 3	Cardiac Massage (closed/open)
1 2 3	Anesthesia (IV/regional block)	1 2 3	Central Lines
1 2 3	Arthrocentesis	1 2 3	Foreign Body Removal
1 2 3	Cardiac Electroconversion	1 2 3	Gastric Lavage
1 2 3	Cricothyotomy	1 2 3	Lumbar Puncture
1 2 3	Endotracheal intubation (nasal/oral)	1 2 3	Nasal Packing/Cautery
1 2 3	Fracture/Dislocation (Reduc./Immobil.)	1 2 3	Wound repair/Dressing
1 2 3	Incision/Drainage	1 2 3	Paracentesis
1 2 3	Interosseous IV	1 2 3	Pericardiocentesis
1 2 3	Nail Trephination/Removal	1 2 3	Surgical Debridement
1 2 3	Pacemaker/IV or transcutaneous	1 2 3	Thoracostomy Tube Drainage
1 2 3	Peritoneal Lavage	1 2 3	Treatment of common orthopedic problems
1 2 3	Spinal Immobilization	1 2 3	
1 2 3	Thoracentesis	1 2 3	
1 2 3	Precipitous Vaginal Delivery	1 2 3	
1 2 3	Diagnosis & treatment of common cardiac arrhythmias		
1 2 3	Familiar with Public Health recommendations regarding venereal disease		
1 2 3	Diagnosis/mangement of respiratory failure, including mechanical ventilation		

Physician's Signature

Printed Name

Date



Hospitalist Delineation

Please circle the appropriate number for each item

1 - I am familiar with this procedure/have performed and competent to perform

2 - I have not performed, but I have been trained; competent to perform

3 - I have not performed, and I am not comfortable in performing

- | | | | |
|-------|---|-------|---|
| 1 2 3 | Arterial catheterization for monitoring | 1 2 3 | Paracentesis |
| 1 2 3 | Arterial puncture for ABG | 1 2 3 | Pericardiocentesis - emergent |
| 1 2 3 | Arthrocentesis | 1 2 3 | Placement transvenous pacer |
| 1 2 3 | Bone marrow biopsy | 1 2 3 | Rhythm strip interpretation |
| 1 2 3 | Bone marrow aspirate | 1 2 3 | Simple Peripheral IV catheter |
| 1 2 3 | Bronchoscopy, diagnostic | 1 2 3 | Swan-Ganz catheter |
| 1 2 3 | Cardioversion - emergent | 1 2 3 | Thoracentesis |
| 1 2 3 | Central venous catheter placement and management | 1 2 3 | Thrombolysis infusion |
| 1 2 3 | Chest tube | 1 2 3 | Ventilator management |
| 1 2 3 | Code Team Leader | 1 2 3 | Endotracheal intubation |
| 1 2 3 | Conscious sedation | 1 2 3 | Lumbar puncture |
| 1 2 3 | External jugular catheterization | 1 2 3 | Neonatal Privileges |
| 1 2 3 | External/transcutaneous pacemaker | 1 2 3 | Suprapubic Bladder Catheterization |
| 1 2 3 | Aspiration & Joint injection | 1 2 3 | Interosseous IV |

Physician's Signature

Printed Name

Date



Past and Pending Claims Information

*Please copy this form for each incident reported



Physician Name: _____

Date of Incident: _____ **Date of Claim:** _____

Patients Name: _____ **Age:** _____ **Sex:** _____

Nature of treatment and diagnosis at time of incident:

Allegations made against you:

Did the patient expire? Yes _____ **No** _____

Disability: _____

Was the case settled? Yes _____ **No** _____ **Amount of settlement?** _____

Pending: _____ **Settled:** _____

Mediation/Arbitration: _____ **Suit Dropped:** _____

Trial: _____

Names of other doctors and hospitals, if any, involved in the claim of this suit:

Date completed

Signature of Applicant

Billing Information

In order to expedite the billing process for the facilities you will be working at, please provide the following information:

Physician Name: _____

NPI Number: _____

UPIN Number: _____

Medicare Number: _____

Medicaid Number: _____

Drivers License Number: _____

Drivers License Expiration Date: _____

Drivers License State: _____



Authorization for Enumeration for NPI

I, _____ (please print name and credentials), with
_____ (name of group), hereby authorize Emergency
Staffing Solutions (ESS) to cause to be submitted an application enumeration under
the NPI system (NPPES) on my behalf.

I further authorize ESS to acquire a user name and log-in ID for the NPPES account
created in my name, to enable updates and correction to the information as required
by the rules and regulation governing the National Provider Identifier standard. I will
supply any changes and correction to such information to ESS in a timely fashion, to
allow them to appropriately perform this function on my behalf.

This authorization shall continue until such time as: 1) I request in writing, ESS to turn
over the NPPES user name and log-in ID to me for upkeep on my account, or 2) I am
no longer affiliated with the group, name above, or 3) until the relationship between
the group and ESS terminates, pursuant to the terms of the Billing Services Agreement
between the same.

Executed this _____ day of _____ (month), _____ (year)

Signature



STATE OF ILLINOIS

Health Care Professional Credentialing and Business Data Gathering Form

The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that this form be collected from health care professionals by hospitals, health care entities, and health care plans which desire to credential such professional. Each hospital, health care entity, and health care plan may also require completion of supplemental forms.

INSTRUCTIONS

This form is for initial credentialing only. Other forms are required for recredentialing and for updating information. YOU ONLY HAVE TO FILL OUT AND SUBMIT WHAT IS REQUESTED BY THE CREDENTIALING ENTITY. PLEASE REFER TO THE INSTRUCTIONS PROVIDED TO YOU BY THE ORGANIZATION YOU ARE APPLYING TO FOR THEIR REQUIREMENTS.

This form has been segmented into two (2) different Chapters, each containing various sections:

- Chapter A: Practice and Professional Information
- Chapter B: Business Information

As previously noted, please consult the specific credentialing entity instructions for their individual Chapter or Section requirements for submission.

GENERAL INSTRUCTIONS: Wherever this application requests information but does not provide sufficient space to provide a complete response (for example, you have more licenses, specialties, work history, etc.) provide attachments which contain all of the information requested in the relevant section OR duplicate the relevant section as many times as necessary and attach it to the back of this application.

The data marked as “Confidential Information” shall be maintained in confidence to the extent required by law. They may be used by the health care plan, entity or hospital and by their agents for credentialing and internal business purposes. Other data contained in this form may be released.

ATTACHMENTS

Attach forms A-F as needed to support “yes” responses in Section J: Professional History and copies of the following:

<input type="checkbox"/> Curriculum Vitae
CONFIDENTIAL INFORMATION: <ul style="list-style-type: none"><input type="checkbox"/> All Current Professional Licenses<input type="checkbox"/> Current Federal DEA License, If Applicable<input type="checkbox"/> Current State Controlled Substance License(s), If Applicable<input type="checkbox"/> Current Professional Liability Insurance Face Sheet or Declaration of Insurance with Effective Date, Expiration Date and Amount Displayed per Occurrence and In Aggregate<input type="checkbox"/> Current CLIA Certificate, If Applicable<input type="checkbox"/> Current W-9s, If Applicable<input type="checkbox"/> ECFMG Certificate, If Applicable<input type="checkbox"/> Professional School Diploma, Residency Certificates, Fellowship Certificates, and Board Certifications, As Applicable

AFFIRMATION OF INFORMATION

I represent and warrant that all of the information provided and the responses given are correct and complete to the best of my knowledge and belief. I understand that falsification or omission of information may be grounds for rejection or termination, in addition to any penalties provided by law. I further agree to promptly inform all entities to which this form was sent and not rejected of any change required to be updated by the Health Care Professional Credentialing and Business Data Gathering Update Form.

I understand that this application does not entitle me to participation in any hospital, health care entity, or health plan.

Applicant’s Signature

Type or Print Name

Date

**** PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTITY, AND HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN ATTESTATION AND RELEASE OF INFORMATION FORM. ****

**CHAPTER A:
PRACTICE AND PROFESSIONAL INFORMATION**

SECTION A. GENERAL INFORMATION

Name: _____
Last First MI Degree

List other names by which you have been known: _____
Last First MI

If you have been known by other names, please explain why your name changed:

Birth Date: _____ Place of Birth: _____
(mm/dd/yy) City State Country

Sex: Male Female Language Fluency of Applicant: English Other: _____
U.S. Citizen? Yes No Spanish

If no, do you have a legal right to reside permanently and work in the U.S.? Yes No

Resident Visa No: _____	CONFIDENTIAL INFORMATION
Social Security Number: _____	
Emergency Contact Person: _____	
Last	First MI
Telephone Number: _____)	

Mailing Address: _____
Street City State Zip

Daytime Phone: () _____ Fax Number: () _____

E-Mail Address: _____

Check here if you have appended additional information for this section:

(Please continue next page)

SECTION B. PROFESSIONAL INFORMATION

Illinois Professional License Number: _____

License Unlimited? Yes No → If No, please explain limitation: _____

Current and Previous Professional License(s) in Other States

State: _____ License #: _____ Exp. Date: _____ (mm/dd/yy)

License Unlimited? Yes No → If No, please explain limitation: _____

State: _____ License #: _____ Exp. Date: _____ (mm/dd/yy)

License Unlimited? Yes No → If No, please explain limitation: _____

State: _____ License #: _____ Exp. Date: _____ (mm/dd/yy)

License Unlimited? Yes No → If No, please explain limitation: _____

Check here if you have appended additional information for this section:

Current Federal DEA License Number: _____ *CONFIDENTIAL INFORMATION*

DEA License Number Expiration Date: _____ License Unlimited? Yes No

If No, please explain limitation: _____

Check here if you have appended additional information for this section:

Current and Previous State Controlled Substance Number(s):

State: _____	<i>CONFIDENTIAL INFORMATION</i>	CS License #: _____	Expiration Date: _____
			(mm/dd/yy)
State: _____		CS License #: _____	Expiration Date: _____
			(mm/dd/yy)
State: _____		CS License #: _____	Expiration Date: _____
			(mm/dd/yy)

Please identify all limitation related to the above Controlled Substances Number(s) and explain limitation.

Medicare Unique Provider ID# (UPIN): _____

National Provider Identification Number (NPI): _____

Medicaid ID#: _____

X-Ray Certification: State: _____ Certificate #: _____ Expiration Date: _____ (mm/dd/yy)

Check here if you have appended additional information for this section:

COMPLETE FOR EACH SPECIALTY

Specialty I: _____

Are you Board Certified in Specialty I? Yes No

If Yes, name of Certifying Board: _____

Date of Certification: _____ Date of Recertification (if applicable): _____
(mm/yy) (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes No

If Certifying Boards taken, give date: _____ Certification Expiration Date, if Any: _____
(mm/yy) (mm/yy)

If not taken, date scheduled to take Specialty Boards: _____
(mm/yy)

Specialty/Subspecialty II: _____

Are you Board Certified in Specialty II? Yes No

If Yes, name of Certifying Board: _____

Date of Certification: _____ Date of Recertification (if applicable): _____
(mm/yy) (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes No

If Certifying Boards taken, give date: _____ Certification Expiration Date, if Any: _____
(mm/yy) (mm/yy)

If not taken, date scheduled to take Specialty Boards: _____
(mm/yy)

(Please continue next page)

Specialty/Subspecialty III: _____

Are you Board Certified in Specialty III? Yes No

If Yes, name of Certifying Board: _____

Date of Certification: _____ Date of Recertification (if applicable): _____
(mm/yy) (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes No

If Certifying Boards taken, give date: _____ Certification Expiration Date, if Any: _____
(mm/yy) (mm/yy)

If not taken, date scheduled to take Specialty Boards: _____
(mm/yy)

Specialty/Subspecialty IV: _____

Are you Board Certified in Specialty IV? Yes No

If Yes, name of Certifying Board: _____

Date of Certification: _____ Date of Recertification (if applicable): _____
(mm/yy) (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes No

If Certifying Boards taken, give date: _____ Certification Expiration Date, if Any: _____
(mm/yy) (mm/yy)

If not taken, date scheduled to take Specialty Boards: _____
(mm/yy)

Check here if you have appended additional information for this section:

(Please continue next page)

SECTION C. PROFESSIONAL LIABILITY INSURANCE

Please provide information on all professional liability insurance carriers from whom you have received coverage in the past 10 years.

CURRENT PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____
Address: _____
Street City State Zip
Policy Number: _____ Original Effective Date: _____ Expiration Date: _____
(mm/dd/yy) (mm/dd/yy)
Policy Limits: Per Occurrence: \$ _____ Aggregate: \$ _____
Retroactive Date: _____
(mm/dd/yy)
What type of coverage do you have? Claims Made Occurrence
Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?
 Yes No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____
Address: _____
Street City State Zip
Policy Number: _____ Original Effective Date: _____ Expiration Date: _____
(mm/dd/yy) (mm/dd/yy)
Policy Limits: Per Occurrence: \$ _____ Aggregate: \$ _____
Retroactive Date: _____
(mm/dd/yy)
What type of coverage do you have? Claims Made Occurrence
Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?
 Yes No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number: _____ Original Effective Date: _____ Expiration Date: _____
(mm/dd/yy) (mm/dd/yy)

Policy Limits: Per Occurrence: \$ _____ Aggregate: \$ _____

Retroactive Date: _____
(mm/dd/yy)

What type of coverage do you have? Claims Made Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?
 Yes No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number: _____ Original Effective Date: _____ Expiration Date: _____
(mm/dd/yy) (mm/dd/yy)

Policy Limits: Per Occurrence: \$ _____ Aggregate: \$ _____

Retroactive Date: _____
(mm/dd/yy)

What type of coverage do you have? Claims Made Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?
 Yes No

Check here if you have appended additional information for this section:

SECTION D. EDUCATION AND TRAINING

If there are any gaps in your training (greater than 30 days), or if you have not completed any portion of your training, please explain on a separate sheet of paper and attach to this application.

MEDICAL/PROFESSIONAL SCHOOL

Institution Name: _____

Mailing Address: _____
Street City State Zip

Telephone Number: () _____ Fax Number: () _____

Degree: _____ Year Graduated: _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

If you are a graduate of a foreign medical school, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? Yes No

Date Issued: _____ Serial Number for ECFMG: _____
mm/yy

Were you the subject of any disciplinary action during your attendance at this institution? Yes No

(Attach an explanation of a "Yes" answer.) ←

If you attended more than one medical/professional school, please check here and attach an explanation that duplicates the information requested above:

INTERNSHIP

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: () _____ Fax Number: () _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

Type of internship: Rotating Straight → If straight, please list specialty: _____

Did you successfully complete this program? Yes No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? Yes No

(Attach an explanation of a "Yes" answer.) ←

If more than one internship, please check here and attach additional information that duplicates the information requested above:

FIRST RESIDENCY

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: () _____ Fax Number: () _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

Type of residency: _____

Did you successfully complete this program? Yes No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? Yes No
(Attach an explanation of a "Yes" answer.) ←

SECOND RESIDENCY

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: () _____ Fax Number: () _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

Type of residency: _____

Did you successfully complete this program? Yes No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? Yes No
(Attach an explanation of a "Yes" answer.) ←

If more than two residencies, please check here and attach additional information that duplicates the information requested above:

(Please continue next page)

FIRST FELLOWSHIP

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: () _____ Fax Number: () _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

Type of fellowship: _____

Did you successfully complete this program? Yes No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? Yes No

(Attach an explanation of a "Yes" answer.) ←

SECOND FELLOWSHIP

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: () _____ Fax Number: () _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

Type of fellowship: _____

Did you successfully complete this program? Yes No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? Yes No

(Attach an explanation of a "Yes" answer.) ←

If more than two fellowships, please check here and attach additional information that duplicates the information requested above:

(Please continue next page)

TEACHING EXPERIENCE/FACULTY APPOINTMENT (MOST RECENT)

Institution Name: _____


Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: () _____ Fax Number: () _____

Dates: From: _____ To: _____ Rank/Position, if applicable: _____
mm/yy mm/yy

Were you the subject of any disciplinary action during your attendance at this institution? Yes No

(Attach an explanation of a "Yes" answer.) 

TEACHING EXPERIENCE/FACULTY APPOINTMENT (PREVIOUS)

Institution Name: _____


Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: () _____ Fax Number: () _____

Dates: From: _____ To: _____ Rank/Position, if applicable: _____
mm/yy mm/yy

Were you the subject of any disciplinary action during your attendance at this institution? Yes No

(Attach an explanation of a "Yes" answer.) 

If more than two teaching experiences/faculty appointments, please check here and attach additional information that duplicates the information requested above:

(Please continue next page)

MEMBERSHIP STATUS – USE FOR SECTIONS E, F, AND G

Please use the following key to indicate membership status in Sections E (Hospital Membership – Current and Pending), F (Hospital Membership – Previous), and G (Ambulatory Surgery Center Practice) below.

A. Active	E. Suspended / Terminated/ Resigned	I. Provisional
B. Courtesy	F. Active Provisional Staff	J. Affiliate
C. Consulting	G. Senior Staff	K. Pending
D. Adjunct	H. Associate	L. Other (Specify)

SECTION E. HOSPITAL MEMBERSHIP - CURRENT AND PENDING

Please list all hospitals at which you are a member of the Medical Staff and have clinical privileges or have applications for privileges pending. (Include additional sheets if more than three hospitals.)

A. Primary Hospital

Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ **To Present**
From (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: () _____

Department Telephone #: () _____

Any Limitations in Your Area of Specialty at this Hospital? _____

B. Other Hospital

Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ **To:** _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: () _____

Department Telephone #: () _____

Any Limitations in Your Area of Specialty at this Hospital? _____

C. Other Hospital

Hospital Name: _____

Address: _____

Street City State Zip

Membership Status: _____ Dates: _____ To: _____

From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: () _____

Department Telephone #: () _____

Any Limitations in Your Area of Specialty at this Hospital? _____

Check here if you have appended additional information for this section:

SECTION F. HOSPITAL MEMBERSHIP – PREVIOUS

Please list all hospitals where you previously held privileges other than during your Internship/Residency/Fellowship. Use the Membership Status key listed prior to Section E. (Include additional sheets if more than three hospitals.)

A. Hospital Name: _____

Address: _____

Street City State Zip

Membership Status: _____ Dates: _____ To: _____

From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: () _____

Department Telephone #: () _____

Any Limitations in Your Area of Specialty at this Hospital? _____

B. Hospital Name: _____

Address: _____

Street City State Zip

Membership Status: _____ Dates: _____ To: _____

From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: () _____

Department Telephone #: () _____

Any Limitations in Your Area of Specialty at this Hospital? _____

C. Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: () _____

Department Telephone #: () _____

Any Limitations in Your Area of Specialty at this Hospital? _____

Check here if you have appended additional information for this section:

SECTION G. AMBULATORY SURGERY CENTER PRACTICE

Please list all ambulatory surgery centers where you currently have or previously had privileges. Use the Membership Status key at the top of page 13. (Include additional sheets if more than three ambulatory surgery centers.)

A. Primary Ambulatory Surgery Center

ASC Name: _____

Address: _____
Street City State Zip

Telephone: () _____ Fax Number: () _____

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

B. Other Ambulatory Surgery Center

ASC Name: _____

Address: _____
Street City State Zip

Telephone: () _____ Fax Number: () _____

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

C. Other Ambulatory Surgery Center

ASC Name: _____

Address: _____
Street City State Zip

Telephone: () _____ Fax Number: () _____

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

Check here if you have appended additional information for this section:

Previous work place: _____

Address: _____
Street City State Zip

Telephone: () _____ Fax Number: () _____

Title or Professional Occupation: _____

Time in this employment: From: _____ **to:** _____
(mm/yy) (mm/yy)

Previous work place: _____

Address: _____
Street City State Zip

Telephone: () _____ Fax Number: () _____

Title or Professional Occupation: _____

Time in this employment: From: _____ **to:** _____
(mm/yy) (mm/yy)

Previous work place: _____

Address: _____
Street City State Zip

Telephone: () _____ Fax Number: () _____

Title or Professional Occupation: _____

Time in this employment: From: _____ **to:** _____
(mm/yy) (mm/yy)

Previous work place: _____

Address: _____
Street City State Zip

Telephone: () _____ Fax Number: () _____

Title or Professional Occupation: _____

Time in this employment: From: _____ **to:** _____
(mm/yy) (mm/yy)

Check here if you have appended additional information for this section:

(Please continue next page)

SECTION I. PROFESSIONAL REFERENCES

Please list the names of three individuals who have personal knowledge (within the past 12 months) of your current clinical abilities, ethical character and interpersonal skills and who would be willing to provide this information upon request. Do not list partners or department chairpersons. Do not list relatives or people listed elsewhere in this credentialing form.

CONFIDENTIAL INFORMATION

1. **Name:** _____ Title: _____
Last First MI Degree

Specialty: _____

Mailing Address: _____
Street City State Zip

Telephone: () _____ Fax Number: () _____

Relationship: _____ Years Known: _____

2. **Name:** _____ Title: _____
Last First MI Degree

Specialty: _____

Mailing Address: _____
Street City State Zip

Telephone: () _____ Fax Number: () _____

Relationship: _____ Years Known: _____

3. **Name:** _____ Title: _____
Last First MI Degree

Specialty: _____

Mailing Address: _____
Street City State Zip

Telephone: () _____ Fax Number: () _____

Relationship: _____ Years Known: _____

(Please continue next page)

SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL

ADVERSE OR OTHER ACTIONS

Submit with all applications. Please answer the following questions to the best of your knowledge with a “yes” or “no.” If you answer “yes” to any question(s) please complete Form A. Please make copies of Form A as needed and complete one form for each “yes” answer.

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? Yes No
2. Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers? Yes No
3. Have you lost any board certification(s), and/or failed to recertify? Yes No
4. Have you been examined by a Certifying Board but failed to pass? Yes No
5. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank? Yes No
6. Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration?? Yes No
7. Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed? Yes No
8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? Yes No
9. Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license?? Yes No
10. Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs?? Yes No
11. Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues?? Yes No

12. Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO?? Yes No
13. Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision? Yes No

PROFESSIONAL LIABILITY ACTIONS

If you answer yes to any question(s) in this section please complete FORM B. Please make copies of FORM B if needed, and complete one for each yes answer.

1. Have any professional liability judgments ever been entered against you? Yes No
2. Have any professional liability claim settlements ever been paid by you and/or paid on your behalf? Yes No
3. Are there any currently pending professional liability suits, actions and/or claims filed against you? Yes No
4. Has any person or entity ever been sued for your clinical actions? Yes No

LIABILITY INSURANCE

If you answer yes to this question please complete FORM C.

- Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, and/or have had your professional liability insurance coverage canceled, non-renewed or limits reduced ? Yes No

CRIMINAL ACTIONS

If you answer yes to any question(s) in this section please complete FORM D. Please make copies of FORM D if needed, and complete one for each yes answer.

1. Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country? Yes No
2. Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse? Yes No

MEDICAL CONDITION

If you answer yes to this question please complete FORM E.

Do you have a medical condition, physical defect or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety?

Yes No

CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

If you answer yes to any question(s) in this section please complete FORM F. Please make copies of FORM F if needed, and complete one for each yes answer.

- 1. Are you currently engaged in illegal use of any legal or illegal substances? Yes No
- 2. Do you currently overuse and/or abuse alcohol or any other controlled substances? Yes No
- 3. If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety? Yes No
- 4. Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse? Yes No

INVESTMENTS

In the last five (5) years have you and/or a member of your family purchased or made an investment in (other than securities of a publicly traded company), or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, and/or other business dealing with the provision of ancillary health services, equipment or supplies?

Yes No

If Yes, please provide explanation: _____

(Please continue next page)

**CHAPTER B:
BUSINESS INFORMATION**

SECTION K. PRIMARY SITE INFORMATION

Please provide the following information for the primary site at which you practice.

**Primary
Site**

Group/Business Name

Building Name

Office Address – Number and Street – Suite

City County State Zip

() _____
Main Telephone Number Office Administrator – Last First MI

() _____
Beeper Number FAX Number E-mail

() _____
Emergency Number Answering Service

Specialty practiced at this site: _____

Is your practice restricted within your specialty (e.g., by age or type of patient)? Yes No

If yes, describe the restrictions: _____

Briefly describe your practice at this location, including any special practice focus or equipment:

Are you currently accepting new patients at this location? Yes No

If yes, describe any restrictions (e.g., appointment type, patient type): _____

Please provide the number of active patients enrolled with you at this site: _____

Please provide the number of patient visits you have at this site per year: _____

Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours	to	to	to	to	to	to	to

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	Existing Patient
Emergency Care		
Urgent Care		
Symptomatic Care (e.g., sore throat)		
Routine Visits (e.g., blood pressure check)		
Preventive Routine Care (e.g., school or annual physical)		

Please provide the following regarding your practice at this site:

Maximum Number of Appointments per Hour		
Average Waiting Time in Office (from scheduled appointment time to actual examination)		
Average Response Time for Returning Patient Calls:	Acute or Urgent Situation:	
	Emergency Situation:	
	Routine Call:	

Please check all procedures you perform at this site:

<input type="checkbox"/> Age-appropriate immunizations	<input type="checkbox"/> EKG	<input type="checkbox"/> Drawing blood
<input type="checkbox"/> Tympanometry/audiometry screening	<input type="checkbox"/> X-rays	<input type="checkbox"/> Minor surgery
<input type="checkbox"/> Pulmonary function studies	<input type="checkbox"/> Flexible sigmoidoscopy	<input type="checkbox"/> Laceration repair
<input type="checkbox"/> Office gynecology (routine pelvic/PAP)	<input type="checkbox"/> Asthma treatment	<input type="checkbox"/> Allergy skin testing
<input type="checkbox"/> Osteopathic /Chiropractic manipulation	<input type="checkbox"/> IV hydration/treatment	<input type="checkbox"/> Physical Therapy

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

Special Skills of Practitioner: _____

Special Skills of Staff: _____

Languages Spoken by Practitioner: _____

Languages Written by Practitioner: _____

Languages Spoken by Staff: _____

Languages Written by Staff: _____

Is this practice site handicapped accessible (check all that apply)?

Building Parking Wheelchair Restroom

Does this site employ paraprofessionals for direct patient care? Yes No

If yes, is supervision always provided on premises during paraprofessionals' direct patient care?

Yes No

Do the paraprofessional(s) bill under any of your Tax ID Numbers? Yes No

If yes, list Tax ID Numbers used:

CONFIDENTIAL INFORMATION

Lab Service at this site? Yes No

If yes, check whether: Primary Secondary Tertiary

CLIA Waiver: Yes No

If yes, CLIA Expiration Date: _____

Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.

Name: _____

Last First MI Degree

Specialty: _____

Address: _____ Telephone: () _____

Street City State Zip

Availability: Days Nights Weekends Holidays

CONFIDENTIAL INFORMATION: Tax ID #: _____

Name: _____

Last First MI Degree

Specialty: _____

Address: _____ Telephone: () _____

Street City State Zip

Availability: Days Nights Weekends Holidays

CONFIDENTIAL INFORMATION: Tax ID #: _____

Name: _____

Last First MI Degree

Specialty: _____

Address: _____ Telephone: () _____

Street City State Zip

Availability: Days Nights Weekends Holidays

CONFIDENTIAL INFORMATION: Tax ID #: _____

Please provide the following information about physician(s)/practitioner(s) who practice in this office:

Name: _____ Specialty: _____

Last First MI

Name: _____ Specialty: _____

Last First MI

Name: _____ Specialty: _____

Last First MI

SECTION L. PRIMARY SITE TAX INFORMATION

Please provide the following information for your Primary Site. Include tax information for each business arrangement you use at this site. (Please include additional sheets if more than four applicable business arrangements.)

Business Arrangement #1

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: () _____

Business Arrangement #2

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: () _____

Business Arrangement #3

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: () _____

Business Arrangement #4

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: () _____

SECTION M. ADDITIONAL SITE INFORMATION

Please provide the following information for each additional site at which you practice.

Site #	_____						
	Group/Business Name						

	Building Name						

	Office Address – Number and Street – Suite						
	City		County		State		Zip
	()		()		()		()
	Main Telephone Number		Office Administrator – Last		First		MI
	()		()		()		()
	Beeper Number		FAX Number		E-mail		
	()		()				
	Emergency Number		Answering Service				

Specialty practiced at this site: _____

Is your practice restricted within your specialty (e.g., by age or type of patient)? Yes No

If yes, describe the restrictions: _____

Briefly describe your practice at this location, including any special practice focus or equipment:

Are you currently accepting new patients at this location? Yes No

If yes, describe any restrictions (e.g., appointment type, patient type): _____

Please provide the number of active patients enrolled with you at this site: _____

Please provide the number of patient visits you have at this site per year: _____

Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours	to	to	to	to	to	to	to

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	Existing Patient
Emergency Care		
Urgent Care		
Symptomatic Care (e.g., sore throat)		
Routine Visits (e.g., blood pressure check)		
Preventive Routine Care (e.g., school or annual physical)		

Please provide the following regarding your practice at this site:

Maximum Number of Appointments per Hour		
Average Waiting Time in Office (from scheduled appointment time to actual examination)		
Average Response Time for Returning Patient Calls:	Acute or Urgent Situation:	
	Emergency Situation:	
	Routine Call:	

Please check all procedures you perform at this site:

<input type="checkbox"/> Age-appropriate immunizations	<input type="checkbox"/> EKG	<input type="checkbox"/> Drawing blood
<input type="checkbox"/> Tympanometry/audiometry screening	<input type="checkbox"/> X-rays	<input type="checkbox"/> Minor surgery
<input type="checkbox"/> Pulmonary function studies	<input type="checkbox"/> Flexible sigmoidoscopy	<input type="checkbox"/> Laceration repair
<input type="checkbox"/> Office gynecology (routine pelvic/PAP)	<input type="checkbox"/> Asthma treatment	<input type="checkbox"/> Allergy skin testing
<input type="checkbox"/> Osteopathic /Chiropractic manipulation	<input type="checkbox"/> IV hydration/treatment	<input type="checkbox"/> Physical Therapy

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

Special Skills of Practitioner: _____

Special Skills of Staff: _____

Languages Spoken by Practitioner: _____

Languages Written by Practitioner: _____

Languages Spoken by Staff: _____

Languages Written by Staff: _____

Is this practice site handicapped accessible (check all that apply)?

Building Parking Wheelchair Restroom

Does this site employ paraprofessionals for direct patient care? Yes No

If yes, is supervision always provided on premises during paraprofessionals' direct patient care?

Yes No

Do the paraprofessional(s) bill under any of your Tax ID Numbers? Yes No

If yes, list Tax ID Numbers used:

CONFIDENTIAL INFORMATION

Lab Service at this site? Yes No

If yes, check whether: Primary Secondary Tertiary

CLIA Waiver: Yes No

If yes, CLIA Expiration Date: _____

Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.

Name: _____

Last First MI Degree

Specialty: _____

Address: _____ Telephone: () _____

Street City State Zip

Availability: Days Nights Weekends Holidays

CONFIDENTIAL INFORMATION: Tax ID #: _____

Name: _____

Last First MI Degree

Specialty: _____

Address: _____ Telephone: () _____

Street City State Zip

Availability: Days Nights Weekends Holidays

CONFIDENTIAL INFORMATION: Tax ID #: _____

Name: _____

Last First MI Degree

Specialty: _____

Address: _____ Telephone: () _____

Street City State Zip

Availability: Days Nights Weekends Holidays

CONFIDENTIAL INFORMATION: Tax ID #: _____

Please provide the following information about physician(s)/practitioner(s) who practice in this office:

Name: _____ Specialty: _____

Last First MI

Name: _____ Specialty: _____

Last First MI

Name: _____ Specialty: _____

Last First MI

SECTION N. ADDITIONAL SITE TAX INFORMATION

Please provide the following information for each additional site at which you practice. Include tax information for each business arrangement you use at this site. (If there is more than one additional site, or more than five business arrangements at any one site, please copy and complete this page for each additional site and business arrangement.)

Business Arrangement #1

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: () _____

Business Arrangement #2

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: () _____

Business Arrangement #3

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: () _____

Business Arrangement #4

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: () _____

**End Credentialing and Business Data Gathering Form.
Attach Forms A-F As Required.**

FORM B – PROFESSIONAL LIABILITY ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

A. Plaintiff's Name: _____
Last First MI

If court case, Case Name & Case Number: _____

B. Your Involvement in the Care (Attending, Consulting, Etc.): _____

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.): _____

D. Allegations, including Patient Outcome, if Available: _____

E. Date of Incident (mm/yy): _____ F. Date Filed (mm/yy): _____

G. Date Case Closed (mm/yy): _____

Resolution Case: Dismissed Judgment Arbitration Other
 Settlement out of Court Pending Mediation

H. Amount Paid on Your Behalf (if any): \$ _____

I. Professional Liability Insurer Name (if one was involved): _____

J. Insurer Telephone Number: () _____ K. Policy Number: _____

L. Insurer Address (Street, City, State, Zip Code):

Signature: _____ **Date:** _____

FORM D – CRIMINAL ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH incident. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

A. Date of Incident (mm/yy): _____

B. Date of Complaint or Conviction (mm/yy): _____

C. Date of Resolution (mm/yy): _____

D. Type of Resolution (Dismissed, Plea Bargain, Misdemeanor, Felony): _____

E. Allegation(s): _____

F. Details of Incident: _____

G. Actions Taken Against You: _____

H. Current Status of Situation: _____

I. Medical Practice Privileges Affected as a Result of This Situation: _____

Signature: _____ **Date:** _____

FORM E – MEDICAL CONDITION

DUPLICATE this form as necessary to complete a separate sheet for EACH condition. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

A. Describe this medical condition: _____

B. To what extent does or could this condition affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

C. What is the current status of your condition? _____

D. Provide the name and address of your personal physician/health care provider who can provide information about your health condition.

Name				Telephone Number
_____	_____	_____	Degree	() _____
Last	First	MI	Degree	
_____	_____	_____	Degree	() _____
Last	First	MI	Degree	

Signature: _____ **Date:** _____

