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:

- Curriculum Vitae

CONFIDENTIAL INFORMATION:

- All Current Professional Licenses
- Current Federal DEA License, If Applicable
- Current State Controlled Substance License(s), If Applicable
- Current Professional Liability Insurance Face Sheet or Declaration of Insurance with Effective Date, Expiration Date and Amount Displayed per Occurrence and In Aggregate
- Current CLIA Certificate, If Applicable
- Current W-9s, If Applicable
- ECFMG Certificate, If Applicable
- 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:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Degree</th>
</tr>
</thead>
</table>

List other names by which you have been known:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
</tr>
</thead>
</table>

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:  

Social Security Number:  

Emergency Contact Person:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
</tr>
</thead>
</table>

Telephone Number: (  )  

Mailing Address:

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

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):

<table>
<thead>
<tr>
<th>State:</th>
<th>CS License #:</th>
<th>Expiration Date: (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Carrier:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Street   City State Zip</td>
</tr>
<tr>
<td>Policy Number:</td>
<td>Original Effective Date:</td>
</tr>
<tr>
<td>Policy Limits: Per Occurrence: $</td>
<td>Aggregate: $</td>
</tr>
<tr>
<td>Retroactive Date: (mm/dd/yy)</td>
<td></td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Carrier:</th>
<th>Address:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Street   City State Zip</td>
</tr>
<tr>
<td>Policy Number:</td>
<td>Original Effective Date:</td>
</tr>
<tr>
<td>Policy Limits: Per Occurrence: $</td>
<td>Aggregate: $</td>
</tr>
<tr>
<td>Retroactive Date: (mm/dd/yy)</td>
<td></td>
</tr>
</tbody>
</table>

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
<table>
<thead>
<tr>
<th>Carrier:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
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<tr>
<td>Street</td>
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<td></td>
</tr>
<tr>
<td>Policy Number:</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Policy Limits:</td>
</tr>
<tr>
<td>Retroactive Date:</td>
</tr>
<tr>
<td>What type of coverage do you have?</td>
</tr>
<tr>
<td>Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Institution Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address:</td>
<td></td>
</tr>
<tr>
<td>Telephone Number: ( )</td>
<td>Fax Number: ( )</td>
</tr>
<tr>
<td>Degree:</td>
<td>Year Graduated:</td>
</tr>
<tr>
<td>Dates attended: From: ( _/_ ) To: ( _/_ )</td>
<td></td>
</tr>
</tbody>
</table>

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: \( \_ \)

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

<table>
<thead>
<tr>
<th>Institution Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Department Chair or Program Director:</td>
<td>Last Name First Name MI Degree</td>
</tr>
<tr>
<td>Mailing Address:</td>
<td></td>
</tr>
<tr>
<td>Telephone Number: ( )</td>
<td>Fax Number: ( )</td>
</tr>
<tr>
<td>Dates attended: From: ( _/_ ) To: ( _/_ )</td>
<td></td>
</tr>
</tbody>
</table>

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: ____________________________

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: ____________________________

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)
TAKEING 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.

<table>
<thead>
<tr>
<th>A. Active</th>
<th>E. Suspended / Terminated/ Resigned</th>
<th>I. Provisional</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Courtesy</td>
<td>F. Active Provisional Staff</td>
<td>J. Affiliate</td>
</tr>
<tr>
<td>C. Consulting</td>
<td>G. Senior Staff</td>
<td>K. Pending</td>
</tr>
<tr>
<td>D. Adjunct</td>
<td>H. Associate</td>
<td>L. Other (Specify)</td>
</tr>
</tbody>
</table>

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: 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: ______________________

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: ______________________

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

B. Other Ambulatory Surgery Center

ASC Name: ____________________________________________

Address: ____________________________________________

   Street                City                State                Zip

Telephone: (___)  Fax Number: (___)

Membership Status: ______________________ Dates: ______________________

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

C. Other Ambulatory Surgery Center

ASC Name: ____________________________________________

Address: ____________________________________________

   Street                City                State                Zip

Telephone: (___)  Fax Number: (___)

Membership Status: ______________________ Dates: ______________________

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

Check here if you have appended additional information for this section: ☐
SECTION H. WORK HISTORY

List chronologically (most recent first) all work engagements (including employment, self-employment, service as an independent contractor, and military service). Do not duplicate internship, residency, and fellowship information previously reported. If there is any gap of greater than 30 days in chronology, explain it on a separate page.

Current work place:

Address: ____________________________________________

Street City State Zip

Telephone: ( ) Fax Number: ( )

Title or Professional Occupation: ________________________________

Time in this employment: From: ___ to Present

(__/__/__)

Previous work place:

Address: ____________________________________________

Street City State Zip

Telephone: ( ) Fax Number: ( )

Title or Professional Occupation: ________________________________

Time in this employment: From: ___ to ___

(__/__/__)(__/__/__)

Previous work place:

Address: ____________________________________________

Street City State Zip

Telephone: ( ) Fax Number: ( )

Title or Professional Occupation: ________________________________

Time in this employment: From: ___ to ___

(__/__/__)(__/__/__)

Previous work place:

Address: ____________________________________________

Street City State Zip

Telephone: ( ) Fax Number: ( )

Title or Professional Occupation: ________________________________

Time in this employment: From: ___ to ___

(__/__/__)(__/__/__)

Previous work place:

Address: ____________________________________________

Street City State Zip

Telephone: ( ) Fax Number: ( )

Title or Professional Occupation: ________________________________

Time in this employment: From: ___ to ___

(__/__/__)(__/__/__)
<table>
<thead>
<tr>
<th>Previous work place:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Street</td>
</tr>
<tr>
<td>Telephone: (   ) Fax Number: (   )</td>
</tr>
<tr>
<td>Title or Professional Occupation:</td>
</tr>
<tr>
<td>Time in this employment: From: (mm/yy) to: (mm/yy)</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>CONFIDENTIAL INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name:</td>
</tr>
<tr>
<td>Last</td>
</tr>
<tr>
<td>Specialty:</td>
</tr>
<tr>
<td>Mailing Address:</td>
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<td>Telephone:</td>
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<td>2. Name:</td>
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<tr>
<td>Street</td>
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<tr>
<td>Telephone:</td>
</tr>
<tr>
<td>Relationship:</td>
</tr>
</tbody>
</table>

(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)
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**
- **Beeper Number**
- **Emergency Number**
- **Office Administrator – Last First MI**
- **FAX Number**
- **E-mail**
- **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:**

<table>
<thead>
<tr>
<th>Hours</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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</thead>
<tbody>
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<td>to</td>
</tr>
</tbody>
</table>
Please indicate standard patient waiting times to schedule an appointment at this site for:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>New Patient</th>
<th>Existing Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptomatic Care (e.g., sore throat)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Visits (e.g., blood pressure check)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Routine Care (e.g., school or annual physical)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

- [ ] Age-appropriate immunizations
- [ ] Tympanometry/audiometry screening
- [ ] Pulmonary function studies
- [ ] Office gynecology (routine pelvic/PAP)
- [ ] Osteopathic /Chiropractic manipulation
- [ ] EKG
- [ ] X-rays
- [ ] Flexible sigmoidoscopy
- [ ] Asthma treatment
- [ ] IV hydration/treatment
- [ ] Drawing blood
- [ ] Minor surgery
- [ ] Laceration repair
- [ ] Allergy skin testing
- [ ] 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:  
Last First MI Specialty:  ____________________________

Name:  
Last First MI Specialty:  ____________________________

Name:  
Last First MI Specialty:  ____________________________
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: (   ) ________________________
Please provide the following information for each additional site at which you practice.

<table>
<thead>
<tr>
<th>Site #</th>
<th>Group/Business Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Building Name</td>
</tr>
<tr>
<td></td>
<td>Office Address – Number and Street – Suite</td>
</tr>
<tr>
<td>City</td>
<td>County</td>
</tr>
<tr>
<td>(   )</td>
<td></td>
</tr>
<tr>
<td>Main Telephone Number</td>
<td>Office Administrator – Last</td>
</tr>
<tr>
<td>(   )</td>
<td>(   )</td>
</tr>
<tr>
<td>Beeper Number</td>
<td>FAX Number</td>
</tr>
<tr>
<td>(   )</td>
<td>(   )</td>
</tr>
<tr>
<td>Emergency Number</td>
<td>Answering Service</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Hours</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
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<td>to</td>
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<td>to</td>
<td>to</td>
</tr>
</tbody>
</table>
Please indicate standard patient waiting times to schedule an appointment at this site for:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>New Patient</th>
<th>Existing Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
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<tr>
<td>Urgent Care</td>
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<td>Routine Visits (e.g., blood pressure check)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Routine Care (e.g., school or annual physical)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please provide the following regarding your practice at this site:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Number of Appointments per Hour</td>
<td></td>
</tr>
<tr>
<td>Average Waiting Time in Office (from scheduled appointment time to actual examination)</td>
<td></td>
</tr>
<tr>
<td>Average Response Time for Returning Patient Calls</td>
<td>Acute or Urgent Situation:</td>
</tr>
<tr>
<td>Routine Call</td>
<td>Emergency Situation:</td>
</tr>
</tbody>
</table>

Please check all procedures you perform at this site:

- [ ] Age-appropriate immunizations
- [ ] Tympanometry/audiometry screening
- [ ] Pulmonary function studies
- [ ] Office gynecology (routine pelvic/PAP)
- [ ] Osteopathic /Chiropractic manipulation
- [ ] EKG
- [ ] X-rays
- [ ] Flexible sigmoidoscopy
- [ ] Asthma treatment
- [ ] IV hydration/treatment
- [ ] Drawing blood
- [ ] Minor surgery
- [ ] Laceration repair
- [ ] Allergy skin testing
- [ ] 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:  
Last First MI Degree
Specialty:

Name:  
Last First MI Degree
Specialty:

Name:  
Last First MI Degree
Specialty:
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): 

<table>
<thead>
<tr>
<th>CONFIDENTIAL INFORMATION:</th>
<th>Tax ID for this Arrangement:</th>
</tr>
</thead>
</table>

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):  

<table>
<thead>
<tr>
<th>CONFIDENTIAL INFORMATION:</th>
<th>Tax ID for this Arrangement:</th>
</tr>
</thead>
</table>

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):  

<table>
<thead>
<tr>
<th>CONFIDENTIAL INFORMATION:</th>
<th>Tax ID for this Arrangement:</th>
</tr>
</thead>
</table>

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):  

<table>
<thead>
<tr>
<th>CONFIDENTIAL INFORMATION:</th>
<th>Tax ID for this Arrangement:</th>
</tr>
</thead>
</table>

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

Applicant Name: ________________________________ ___________________ ____________________
  Last First MI

Indicate the number of ONE of the questions in Section J to which you answered “yes”: Question Number: ____

A. Describe the circumstances surrounding this occurrence. Please include the date of the occurrence.

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

B. Provide an explanation of any actions taken. Please include the date the action was taken.

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

C. Provide the current status of the issue.

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

D. If known:  Contact: _______________________________________________________________________

  Department/Committee: _____________________________________________________________________

  Address: _____________________________________________________________
  Street __________________ City __________ State __ Zip ____________
  Telephone: (   ) ____________________________

Signature: _____________________________________________________________________________ Date: ____________________________
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: ____________________________

A. Plaintiff’s Name:

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 C – LIABILITY INSURANCE

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. History of Professional Liability Insurance (Please check One)

☐ Canceled Voluntarily ☐ Non-Renewed

☐ Canceled Involuntarily ☐ Application Denied

B. Carrier Name: ____________________________

C. Carrier Telephone Number: (____)____________

D. Policy Number: ____________________________

E. Carrier Address (Street, City, State, Zip Code):

________________________________________________________

________________________________________________________

F. Dates of Coverage: From (mm/yy): ___________ To (mm/yy): ___________

G. Circumstances Involved: __________________________________________

________________________________________________________

Signature: ____________________________ Date: __________________
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: ________________________________________________________________________

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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone Number</th>
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</tr>
</tbody>
</table>

Signature: ______________________________ Date: __________________
FORM F – CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

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

Applicant Name: ____________________________

Last First MI

Describe the substance you use:

__________________________________________

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

__________________________________________

B. Monitored by State Board Mandate (Name and Address)  C. Monitored Voluntarily (Name and Address)

__________________________________________  ____________________________________________

__________________________________________  ____________________________________________

D. Other information about the current status of your use of substances:

__________________________________________

E. Abstinent since (mm/yy): __________

F. Provide the name and address of your personal physician/health care provider who can provide information about your treatment for alcohol or chemical substance use and can comment on what impact (if any) it has on your current/future professional practice.

Name: _______________________________________

Address: _______________________________________

    Street _____________________________ City __________ State __________ Zip

Telephone: (___) ______

Signature: ________________________________ Date: ____________________