

Additional Addresses

Secondary Practice Address:

Street & Suite #: _____

 City, State, Zip: _____

Secondary Office Phone#: _____

Secondary Office Fax#: _____

After Hours/Answering Service #: _____

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Office Hours:							

Additional Practice Address:

Street & Suite #: _____

 City, State, Zip: _____

Additional Office Phone#: _____

Additional Office Fax#: _____

After Hours/Answering Service #: _____

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Office Hours							

Billing Address: (if different from Primary Practice Address)

Street & Suite #: _____ City, State, Zip: _____

Professional Licenses - Please list all licenses EVER held.

State	License #	Type (Medical, Dental, etc.)	Effective Date	Expiration Date	Currently practice under this license?
____					<input type="checkbox"/> Yes <input type="checkbox"/> No
____					<input type="checkbox"/> Yes <input type="checkbox"/> No
____					<input type="checkbox"/> Yes <input type="checkbox"/> No
____					<input type="checkbox"/> Yes <input type="checkbox"/> No
____					<input type="checkbox"/> Yes <input type="checkbox"/> No
____					<input type="checkbox"/> Yes <input type="checkbox"/> No

Controlled Substances Registration - Please list all certificates ever held.

Issuing Body	Certificate #	Expiration Date	Approved for all schedules (2, 2N, 3, 3N, 4, 5) If No, please explain.
Federal DEA			<input type="checkbox"/> Yes <input type="checkbox"/> No
State: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
State: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No

Professional Liability Insurance - Please list current carrier and previous carrier if you have been covered by current carrier less than five (5) years. (This includes coverage during residency training.)

Current Carrier Information:		
Carrier Name: _____		Policy #: _____
Address: _____		Phone #: _____
Type Policy: <input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	Per Claim Limits: \$ Aggregate Limits: \$	Retroactive Date: Expiration Date:
Previous Carrier Information:		
Carrier Name: _____		Policy #: _____
Address: _____		Phone #: _____
Type Policy: <input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	Per Claim Limits: \$ Aggregate Limits: \$	Retroactive Date: Expiration Date:

Specialty Board Certification(s)

Certifying Board	Specialty Certified In	Original Issue Date	Expiration Date	Do you practice this specialty?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
If not certified, are you actively involved in the certifying process? If yes, please document status in process (e.g. copy of letter of acceptance to sit for exam). Scheduled Date of Exam: _____				<input type="checkbox"/> Yes <input type="checkbox"/> No
If not certified, have you ever taken and failed a certification exam? Please explain: _____				<input type="checkbox"/> Yes <input type="checkbox"/> No

Education/Training - Attach additional pages as needed.

1. Graduate Education: (e.g., Medical/Dental/Podiatric School)		
School Name: _____		Phone #: _____
Address: _____		FAX #: _____
City, State, Zip: _____		Email: _____
Country: _____		Contact: _____
If foreign medical school, indicate ECFMG or SPEX number: _____		Date: _____
Dates Attended: _____	MMYY to _____ MMYY	Degree Received: _____
2. Additional Graduate Education:		
School Name: _____		Phone #: _____
Address: _____		FAX #: _____
City, State, Zip: _____		Email: _____
Program Name: _____		Program Director: _____
Dates Attended: _____	MM/YY to _____ MM/YY	Degree Received: _____

Education/Training Continued

3. Post-Graduate Training: (Internship - if not included under Residency Training below)

School Name: _____ Phone #: _____
 Address: _____ FAX #: _____
 City, State, Zip: _____ Email: _____
 Program Director: _____

Dates Attended: _____ MMY Y to _____ MMY Y Transtnl 5th Pthwy Rotating Prelim

4. Post-Graduate Training: (Residency)

School Name: _____ Phone #: _____
 Address: _____ FAX #: _____
 City, State, Zip: _____ Email: _____
 Program Director: _____

Dates Attended: _____ MMY Y to _____ MMY Y Specialty: _____

5. Post-Graduate Training: Residency Fellowship

School Name: _____ Phone #: _____
 Address: _____ FAX #: _____
 City, State, Zip: _____ Email: _____
 Program Director: _____

Dates Attended: _____ MMY Y to _____ MMY Y Specialty: _____

6. Post-Graduate Training: Residency Fellowship

School Name: _____ Phone #: _____
 Address: _____ FAX #: _____
 City, State, Zip: _____ Email: _____
 Program Director: _____

Dates Attended: _____ MMY Y to _____ MMY Y Specialty: _____

Faculty/Teaching Appointments

University Name and Address	Appt Dates (MMYY to MMY Y)	In order for us to verify this appointment, please provide the following:
School Name: _____ Address: _____ City, State, Zip: _____ Your Position: _____	From: _____ To: _____	Phone #: _____ FAX #: _____ Email: _____
School Name: _____ Address: _____ City, State, Zip: _____ Your Position: _____	From: _____ To: _____	Phone #: _____ FAX #: _____ Email: _____

Professional (Medical/Dental) Staff Appointments/Privileges

Please note **PAST** and **PRESENT** Affiliations, including Locum Tenens (Attach additional pages as needed.)

Hospital Name and Address: _____		Contact Information: (for verification purposes)	
Facility: _____		Contact: _____	
Address: _____		Phone#: _____ FAX#: _____	
City, State, Zip: _____		Email: _____	
From: _____ To: _____		<input type="checkbox"/> Active/Attending <input type="checkbox"/> Courtesy <input type="checkbox"/> Referring <input type="checkbox"/> Other: _____	
Facility: _____		Contact: _____	
Address: _____		Phone#: _____ FAX#: _____	
City, State, Zip: _____		Email: _____	
From: _____ To: _____		<input type="checkbox"/> Active/Attending <input type="checkbox"/> Courtesy <input type="checkbox"/> Referring <input type="checkbox"/> Other: _____	
Facility: _____		Contact: _____	
Address: _____		Phone#: _____ FAX#: _____	
City, State, Zip: _____		Email: _____	
From: _____ To: _____		<input type="checkbox"/> Active/Attending <input type="checkbox"/> Courtesy <input type="checkbox"/> Referring <input type="checkbox"/> Other: _____	
Facility: _____		Contact: _____	
Address: _____		Phone#: _____ FAX#: _____	
City, State, Zip: _____		Email: _____	
From: _____ To: _____		<input type="checkbox"/> Active/Attending <input type="checkbox"/> Courtesy <input type="checkbox"/> Referring <input type="checkbox"/> Other: _____	
Facility: _____		Contact: _____	
Address: _____		Phone#: _____ FAX#: _____	
City, State, Zip: _____		Email: _____	
From: _____ To: _____		<input type="checkbox"/> Active/Attending <input type="checkbox"/> Courtesy <input type="checkbox"/> Referring <input type="checkbox"/> Other: _____	

Military Service or Other Practice History - Please list any other activities/affiliations not listed under Education/Training, Faculty/Teaching Appointments, or Professional Staff Appointments.

There should be no unexplained gaps from date of completion of graduate school to the present.

Attach additional pages as needed.

Activity/Affiliation (Ex: Military Service, etc)	
Facility: _____	Contact: _____
Address: _____	Phone#: _____ FAX#: _____
City, State, Zip: _____	Email: _____
From: _____ To: _____	Title/Activity: _____
Facility: _____	Contact: _____
Address: _____	Phone#: _____ FAX#: _____
City, State, Zip: _____	Email: _____
From: _____ To: _____	Title/Activity: _____
Gaps in work history: (Ex: Personal Leave, etc. - Attach additional pages as needed.)	
From: _____ To: _____	Explanation: _____
From: _____ To: _____	Explanation: _____

Solo Practitioners - Practice Coverage

If you are a **solo practitioner**, you must have practice coverage by a practitioner(s) in your specialty.

They must have privileges at the facility where they agree to provide practice coverage.

Practitioner Name	Phone #	Does this practitioner agree to the fees and administrative procedures of the networks with which you contract?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Partnerships/Multi-Physician Groups: If you practice in a partnership or multi-physician group, please list each practitioner's name and specialty and the offices in which he/she practices. **Please indicate which of your partners have privileges at the facility where they agree to provide practice coverage.**

Practitioner Name	Specialty	Office(s) in which he/she practices

Peer References - Three (3) professional peers of your discipline (M.D., D.O., D.M.D., D.D.S.) with at least one in your specialty, who have **CURRENT knowledge** of your professional performance, clinical judgment and clinical/technical skills. This individual **may not be** related to you by family or marriage or be a former program director.

Practitioner Name and Address	In order for us to contact this reference, please provide the following:
Peer Name/Title: _____ Practice Name: _____ Practice Address: _____ _____ Practitioner's Specialty: _	Office Phone # _____ Office FAX #: _____ Email: _____
Peer Name/Title: _____ Practice Name: _____ Practice Address: _____ _____ Practitioner's Specialty: _	Office Phone # _____ Office FAX #: _____ Email: _____
Peer Name/Title: _____ Practice Name: _____ Practice Address: _____ _____ Practitioner's Specialty: _	Office Phone # _____ Office FAX #: _____ Email: _____

Health Status

Are you able to perform the requested privileges in a safe and competent manner? (If response is NO or special accommodations are necessary, please explain separately.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you presently use illegal drugs? (If response is YES, please explain separately.)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Disciplinary Actions

1. Has any action ever been undertaken, whether it remains pending or has been completed, involving but not limited to denial, revocation, suspension, obligation(s), reduction, limitation, probation, non-renewal, involuntary or voluntary relinquishment or withdrawal in connection with:	
(a) Your membership status, clinical privileges at any hospital, employment relationship, IPA, HMO, PHO, PPO, managed care organization, or institution?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Your membership or fellowship in any local, state, regional, national or international professional organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Your license to practice any profession in any jurisdiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Your Drug Enforcement Administration or other controlled substances registration?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) Your specialty board certification and/or professional school faculty position or membership?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, state, or federal health insurance program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been charged with, convicted of, pled <i>nolo contendere</i> to, or paid a fine for (or are you currently being investigated for or do you currently have charges pending for) a criminal offense (excluding minor traffic violations), including, without limitation, a criminal offense related to Medicare, Medicaid, or any other federal program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever 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 of a civil, criminal or administrative action) regarding sexual misconduct, child abuse (or other crime involving children), violence (including domestic) or elder or vulnerable adult abuse (or other crime involving the elderly or vulnerable adults)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever been expelled, excluded, or suspended from any federal program or from service reimbursement under Medicare or Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has your professional liability insurance coverage ever been denied, canceled, reduced, limited, not renewed or terminated by action of an insurance company?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has your professional liability insurance carrier ever excluded you from performing any specific privileges within your specialty?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever had any judgments entered against you or settlements made on your behalf in any of your professional liability claims?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Are you on notice of any medical malpractice claims pending against you (including a Notice of Intent to initiate litigation for medical malpractice) or have you ever been named as a defendant in a professional liability action?	<input type="checkbox"/> Yes <input type="checkbox"/> No

IMPORTANT: If the answer to any of the above questions is YES, please explain separately.

Application Routing:

<p>Currently on staff at the following hospital(s) (put an X in all that apply)</p> <p><input type="checkbox"/> Baptist Medical Center Jacksonville Wolfson Children's Hosp</p> <p><input type="checkbox"/> Baptist Medical Center-Beaches</p> <p><input type="checkbox"/> Baptist Medical Center-Nassau</p> <p><input type="checkbox"/> Baptist Medical Center-South</p> <p><input type="checkbox"/> Brooks Rehab Hospital</p> <p><input type="checkbox"/> UF Health Jacksonville</p> <p><input type="checkbox"/> St. Vincent's Southside</p> <p><input type="checkbox"/> St. Vincent's Riverside</p> <p><input type="checkbox"/> St. Vincent's Clay County</p>	<p>Applying to the following hospital(s) at this time (put an X in all that apply)</p> <p><input type="checkbox"/> Baptist Medical Center Jacksonville Wolfson Children's Hosp</p> <p><input type="checkbox"/> Baptist Medical Center-Beaches</p> <p><input type="checkbox"/> Baptist Medical Center-Nassau</p> <p><input type="checkbox"/> Baptist Medical Center-South</p> <p><input type="checkbox"/> Brooks Rehab Hospital</p> <p><input type="checkbox"/> UF Health Jacksonville</p> <p><input type="checkbox"/> St. Vincent's Southside</p> <p><input type="checkbox"/> St. Vincent's Riverside</p> <p><input type="checkbox"/> St. Vincent's Clay County</p>
<p>Of the hospitals you are applying to at this time, only ONE will conduct the primary source verifications. Please indicate which ONE facility will be the primary hospital.</p> <p><input type="checkbox"/> Baptist Medical Center Jacksonville Wolfson Children's Hosp</p> <p><input type="checkbox"/> Baptist Medical Center-Beaches</p> <p><input type="checkbox"/> Baptist Medical Center-Nassau</p> <p><input type="checkbox"/> Baptist Medical Center-South</p> <p><input type="checkbox"/> Brooks Rehab Hospital</p> <p><input type="checkbox"/> UF Health Jacksonville</p> <p><input type="checkbox"/> St. Vincent's Southside</p> <p><input type="checkbox"/> St. Vincent's Riverside</p> <p><input type="checkbox"/> St. Vincent's Clay County</p>	<p>In the event of a disaster, to which hospital would you mostly likely respond?</p> <p><input type="checkbox"/> Baptist Medical Center Jacksonville Wolfson Children's Hosp</p> <p><input type="checkbox"/> Baptist Medical Center-Beaches</p> <p><input type="checkbox"/> Baptist Medical Center-Nassau</p> <p><input type="checkbox"/> Baptist Medical Center-South</p> <p><input type="checkbox"/> Brooks Rehab Hospital</p> <p><input type="checkbox"/> UF Health Jacksonville</p> <p><input type="checkbox"/> St. Vincent's Southside</p> <p><input type="checkbox"/> St. Vincent's Riverside</p> <p><input type="checkbox"/> St. Vincent's Clay County</p>

Attestation:

I hereby affirm that the information furnished by me in connection with this application is correct and complete to the best of my knowledge and is furnished in good faith.

I agree to notify each healthcare entity to which I am applying for appointment and privileges, should there be any changes in licensure, professional liability coverage (including judgments or settlements made on my behalf), DEA certification, and physical or mental health status, in accordance with each entity's required reporting timeframes.

Print Name of Applicant

Signature of Applicant

Date