01/22/2013 LASTATTESTATION DATE

Provider Application

CORRECT NUMBERS AND LETTERS:	ABC 123 CORRECT X INCORRECT V		
Instructions Read all instructions carefully prior to submitting your application.	Tips to avoid processing delays: 1. Complete only this application and its supplemental forms. Do not use another prov 2. Use a blue or black ink ball-point pen only. Do not use a pencil or a fell-tip pen. 3. Print legibly and inside the boxes provided based upon the examples given above. 4. Do not enter more than 1 character per box. If necessary, write outside the provided 5. Complete all sections that are applicable to you. 6. Some fields use "codes" to help you easily report information (e.g., schools, language NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be	spaces. es). Code lists are fo	
SECTION 1	Personal Information and Professional IDs		
Provider Type	MD YES X NO (EX. PATHOLOGIST		THE INPATIENT SETTING?" 'S, ER PHYSICIANS, NURSE IN ASSISTANT, ETC.)
Name Da not use nicknames or initials, unless they are part of your legal name.	Singh LAST NAME: Pariksith		SUFFIX (JR, In)
	FIRSY NAME: HAVE YOU EVER USED ANOTHER NAME? YES X NO IF YES, PLEASE LIST ALL OTHER	HT QNA CHEU SHAAN F	EIR DATES OF USE:
	OTHER LAST NAME	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	SUFFIX (JR, XI)
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	DATE STARTED USING OTHER NAME DATE STOPPED USING OTHER NAME	MANAGEMENT TRANSPORTED TO THE RESIDENCE OF THE PERSON OF T	······································
Seneral Information Only enter a Foreign	GENDER': X MALE FEMALE DATE OF BIRTH 05/07/1968		
National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI)	Rajasthan GITYOF BIRTH	STATE OF BIRTH	India COUNTRY OF BIRTH
Number here. Code lists are found on pages 36-43. Enter the	SSN*: 052-82-9007 FOREIGN NATIONAL IDENTIFICATION NUMBER	er (Frin)	FNIN COUNTRY OF ISSUE
associated 3-digit code in the space provided.	ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK: LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE
Home Address	7443 Oak Tree Lane		
	Spring Hill	FL STATE	34607 ZIP CODE
	TELEPHONE 3525853690		
NOTE: CAQH will use this method for application follow-up.	E-MAIL:		
•	FAX: (352) 688-7940		
			_

* REQUIRED RESPONSE INDIRESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Personal Information and Professional IDs (Continued) Section 1 **Professional** BS4971354 02/01/2011 iDs FEDERAL DEA NUMBER OEA ISSUE DATE: include all state licenses, DEA 02/28/2014 Registration and State DEA STATE OF REGISTRATION DEA EXPIRATION DATE Controlled Dangerous Substance (CDS) certification numbers. Provide all current and CDS ISSUE DAYE: CDS CERTIFICATE NUMBER previous #censes/ certifications. CDS EXPERATION DATE: CDS STATE OF REGISTRATION Non-Rensed professionals should FL 01/15/2011 ME71088 enter certification/ LICENSE ISSUING SYATE LICENSE ISSUE DATE: registration number in STATE LICENSE NUMBER the space provided for IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? Scense sumber. NO 01/31/2013 If you have additional LICENSE EXPIRATION DATE: Professional IDs to report, use the MD Active Professional IDs Supplemental Form on LICENSE STATUS page 19. LICENSE ISSUING STATE STATE LICENSE NUMBER LICENSE ISSUE DATE: IF THIS IS A STATE LICENSE, ARE YOU VES NO CURRENTLY PRACTICING IN THIS STATE? LICENSE EXPIRATION DATE: LICENSE STATUS LICENSE TYPE Other ID ARE YOU A PART-ICIPATING MEDICARE NO 31545S G65154 YES Numbers Hillian MEDICARE NUMBER ARE YOU A PARTif you have additional ICIPATING MEDICAID 253729000 Professional IDs to FL PROVIDER? report, use the MEDICAID NUMBER MEDICAID STATE Professional IDs Supplemental Form on page 19. 1417989625 USMLE NUMBER (WITHOUT HYPHENS) NPI NUMBER WORKERS COMPENSATION NUMBER 04815080 11/07/1992 ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY) ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE CHLY)

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Section 2 Education and Training (Continued) Training New York Medical College AFFILIATED MEDICAL SCHOOL List all training programs you Mount Sinai-NYU Hospitals attended. Use one section per institution. INSTITUTION/HOSPITAL NAME if you have additional One Gustave Levy Place post-graduate training programs, use the STREET SUITE/BLDG. Supplemental Training Form on page 21. 10019 New York NY POSTAL CODE Please explain on the Supplemental Professional / Work United States History Gap Form on COUNTRY FAX page 33 any training TELEPHONE gap(s) of three (3) DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS months or greater, or any gap(s) of a shorter YES (IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIM.) duration if required by the organization for which you are being credentialed. Code lists are found on pages 36-43. Enter the associated 3-digit code. in the space provided. X INTERNSHIP List each FELLOWSHIP 02/1996 02/1993 department START DATE separately, if applicable. Internal Medicine List DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE) internship/ Residency, Fellowship and Other NAME OF DIRECTOR សល្បានពាទ separately. **|NYERNSHIP/** FELLOWSHIP OTHER RESIDENCY START DATE END DYTE DEPARTMENT/SPECIALTY (DO NOT ABBREYIATE) NAME OF DIRECTOR (心性性会対気域(性) FELLOWSHIP OTHER RESIDENCY START DATE END DATE DEPARTMENT/SPECIALTY (DO NOT ARBREVIATE) NAME OF DIRECTOR

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* REQUIRED RESPONSE, NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

REQUIRED RESPONSE, NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOWUP Professional / Medical Specialty Information Section 3 DO YOU WISH TO BE LISTED IN special, ty: Internal Medicine Primary 11/01/1996 CERTIFICATION THE DIRECTORY Specialty DA TE: UNDER THIS RECERTIFICATION DATE SPECIAL TY7 CERTIFIED? X YES 12/31/2006 Ν¢ Code lists are found on (IF APPLICABLE): pages 36-43. Enter the associated 3-digit code CERTIFYING BOARD; EXPIRATION DATE 12/31/2016 in the space provided. NO (IF APPLICABLE): American Board of Internal Medicine HAVE TAKEN I DO NOT INTEND TO TAKE INTEND TO SIT FOR AN BOARD CERTIFIED EXAM, RESULTS PENDING FOR: A CERTIFYING BOARD EXAM. EXAM ON: IF CHECKED, PLEASE EXPLAIN WHY YOU DO NOT INTEND TO (SELECT ONE): TAKE THE EXAM IN THE SPACE CERTIFYING BOARD if you indicated that you did not intend to take a certifying board exam, please use the space above to explain. Otherwise, leave the space above blank. DO YOU WISH TO BE LISTED IN INTIAL Secondary нмо YES NO CERTIFICATION DATE THE DIRECTORY Specialty RECERTIFICATION SPECIALTY? BOARD YES (F APPLICABLE): Code lists are found on CERTIFIED? pages 36-43. Enter the CERTIFYING associated 3-digit code EXPIRATION DATE (IF APPLICABLE): BOARD: YES in the space provided. If you have additional IF NOT THAVE TAKEN LINTEND TO SIT FOR AN LOO NOT INTEND TO TAKE Professional / Medical BOARD EXAM. RESULTS PENDING FOR: CERTIFYING BOARD EXAM EXAM ON: Specialties to report, Cをおわれ他の (SELをCT ONE): IF CHECKED, PLEASE EXPLAIN WHY YOU DO NOT INTEND TO TAKE THE EXAM IN THE SPACE use the Additional Specialites Supplemental Form on page 22. CERTIFYING BOARD CODE if you indicated that you did not intend to take a certifying board exam, please use the space above to explain otherwise, leavy the space above blank.

> 3081 ★ REQUIRED RESPONSE, NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW/UP

Section 3	Professional / Medical Specialty Inf	ormation (Continued			
Certifications	Do you hold the following certifications? If yes, provide EXPRATION DATE: GASTO LIFE SUPPORTY. YES NO 01/31/2007 CPRY. X YES NO 01/31/2007 ADV CARDIAC LIFE SPTY. NEONATAL ADVANCED LIFE SPTY. NO 01/31/2007	expiration dates. ADV LIF SUPPOR ADV TRI LIFE SUPPOR PEDIATE ADVANC LIFE SP	TIN YES X NO	EXPIRATION C	ATE:
Practice interests: Provide additional areas of professional practice interest, activities, procedures, diagnoses or populations.					
Primary Credentialing Contact CHECK HERE TO USE THE OFFICE MANAGER AND ADDRESS OF THE PRIMARY PRACTICE LOCATION AS THE CREDENTIALING INFORMATION. Note: Even if you checked the boxes above, please provide the e-mail address, if available.	Emerick Annmarie FIRST NAME 12225 28th Street North Suite A ADDRESS St Petersburg GITY (727) 823-2188 TELEPHONE americk9a6@medenet.net EMAIL ADDRESS	(727) 828-0723		FL	33716-1860 ZIP CODE
l	t T	3082			

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* REQUIRED RESPONSE, NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP Section 4 Practice Location Information NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY MITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE CINLY REQUIRED TO COMPLETE THE CREDENTIALING CONTACT DUESTION ABOVE: SECTION 4 MAY BE LEFT BLANK, YOU MAY PROCEED TO SECTION 5 ON PAGE 11: Primary Practice CURRENTLY Location X YES PRACTICING AT THIS ADDRESS?" 07/01/2011 OR FUTURE START DATE? If you have additional ACCESS HEALTH CARE PHYSICIANS LLC practice locations, use the Supplemental PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE) Practice Location Information Form on ACCESS HEALTH CARE PHYSICIANS LLC pages 25-29. DROUP / CORPORATE NAME AS IT APPEARS ON W.4. IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE) NOTE: 'General 5350 SPRING HILL DR Correspondence" refers ADDRESS* to any correspondence that might be sent to the 34606 4562 provider that does not SPRING HILL solely relate to credentialing or billing SENU GENERAL information. (352) 688-7940 CORRESPON-DENCE HERE? (352) 688-8116 TIP: Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify OFFICE E-MAIL ADDRESS otherwise to the right. PRIMARY USE INDIVIDUAL TAX ID USE GROUP TAX ID *45-144488*3 59-3682760 (ONE ONLY)": GROUP TAX ID DI KAT JAUGIVICIAL Office Manager Burrkhardt or Business LAST NAME Office Staff Contact Diane FIRST NAME & M.I." List each contact separately. You may (352) 686-9477 use the check boxes (352) 688-8116 below for convenience. **よちずないりかぎ、** Do not write instructions like "see dburkhardt@accesshealthcarellc.net above. These responses will be E-MAIL ADDRESS rejected and will require follow-up. **Billing Contact** Patel LASTNAME CHECK HERE TO USE OFFICE val MANAGER AND M.I. FIRST NAME OFFICE ADDRESS AS BILLING INFORMATION P.O. Box 636233 SULTERBLOG STREET 45263 OH Cincinnati Note: ZIP CODE STATE Even if you checked (352) 593-4994 (352) 593-4101 the box above, please provide the TELEPHONE. E-mail Address of the Billing Contact. valp@medenet.net

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E-MAIL ADDRESS

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Note:	Cincini	natí					'	STATE*	45263	45263	
Even if you checked the box above, please provide the E-mail Address of the Payee Contact.	(352) 5	93-4101 medenet.net		(352) FAX	593	-4994					
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	TUESDAY:	8:30 am		4:00 pm		SATURDAY:					
	WEDNESDAY:	8:30 am		4:00 pm		SUNDAY:					
Note: After hours back office telephone will be used	THURSDAY:	8:30 am		4:00 pm			MANTA MARKET STATE OF THE STATE				
only by the health plan and will not be published under any circumstances.	24/1 PHONE COVERAGE? IF YES: AFTER HOURS BACK OFFICE TELEPHONE VOICE MAIL. WITH VOICE MAIL. WITH OTHER ANSWERING SERVICE INSTRUCTIONS (352) 666-9912										
Open Practice Status	ACCEPT NEW	PATIENTS INTO THIS PRAC	:17 0 E ?"	X 468	Ю	ACCE	PT ALL NEW PATIENTS?"		X	és NO	
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	ALLEN STORY			
iid-Level ractitione <i>r</i> s	DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?"	X YES NO		
	(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)			
	Lowenstein			
	PRACTITIONER LAST NAME			
	Sharona			PA
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Section 4	Practice Location Information (Continued)	esamensisi aryangsi Marzanjeoniya ilikulaki	candi sola control minimi control (control sola e sun est (signi)
Partners/	LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE		ro
Associates	SCUNZIANO MD	Internal Medicine	X
Code lists are found on	LASTNAME	SPECIALTY	GOVERING COLLEAGUE
pages 35-43. Enter the associated 3-digit code	MARIA		MD
n the space provided.	FIRST NAME		PROVIDER TYPE (MD, ETC.)
fyou have additional			WAR WATER
cartners/associates at THIS location, use the		SPECIAL TY	COVERING
Pertner/Associate Supplemental Form on	LA ST NAME	3. C31172 1 2	COLLEAGUE
age 23. Photocopy as recessary. Be certain			PROVIDER TYPE (MD. ETC.)
o check "Primary Location" at the top of	FIRST NAME		
the page.			
	LASTNAME	SPECIALTY	COVERING
			COLLEAGUE
	FIRST NAME		PROVIDER TYPE (MD, ETC.)
) man		
Covering	LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERSIASS	SOCIATES AT THIS PRACTICE	
Colleagues			
		SPECIALTY	
Code lists are found on pages 36-43. Enter the	LA ST NAME		
associated 3-digit code in the space provided.			PROVIDER TYPE (NO, ETC.)
lfyou have additional	FIRST NAME		
covering colleagues that are not partners at			
this location, use the	LAST NAME	SPECIALTY	
Covering Colleagues Supplemental Form on			
page 24. Photocopy as necessary, Be certain	FIRST NAME		PROVIDER TYPE (MD, ETC.)
to check "Primary Location" at the top of		Marie 111111111111111111111111111111111111	
the page.			
	LAST NAME	SPECIALTY	
	FIRST NAME		PROVIDER TYPE (MD, ETC.)
or contrator and one parameter half out	el adalogo bahanyong-yang-san pakakakakan di senting-yang-saniya kaniya kisikakaying-ki	san saato di camanis akonomina setsa ta tandari cili di di di	- Rimara (1907) e a sala Eri, Afrikai (1914) Eri (1914) e Rai
Section 5	Hospital Affiliations		
Admitting Arrangements	DO YOU HAVE X YES NO FOUND NOT ADMITTING ARRANGEMENTS DO YOU HAVE?	And the state of t	MITATION TO THE
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Section 5 Hospital Privileges

If applicable, list all hospital affiliations, kist primary hospital, then other current affiliations, followed by previous affiliations in chronological order.

If you have additional hospital privileges, use the Supplemental Hospital Privileges Form on page 30.

TIP: Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this your.

Hospital Affiliations	(Continued)			
PRIMARY HOSPITAL				
Brooksville and S	pring Hill Regional H	iospital		
HOSPITAL NAME				
10461 Quality Dr				
ADDRESS				
Brooksville			<u>FL</u>	34609
CHA			STATE	ZIPCODE
TELEPHONE	FAX			
MEDICINE				
DEPARTMENT NAME				
DEPARTMENT DIRECTOR LAST NA	ME			
DEPARTMENT DIRECTOR FIRST NA	ME & M.I.			
01/2012	12/2013	PRIVILEGES?	YES NO AREP	RIVILEGES YES X NO
AFFILIATION START DATE	AFFILIATION END DATE			
Active			OF YOUR TOTAL ANNUAL	
	G. NONE. FULL UNRESTRICTED, PROVI	SIONAL, TEMPORARY)	ADMISSIONS, WHAT PERG IS TO THIS HOSPITAL?	JENIAGE JU
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OTHER HOSPITAL				
Medical Center Tr	inity			
HOSPITAL NAME	AND			<u> </u>
9330 St Rd 54				
ACORESS	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	***************************************		· · · · · · · · · · · · · · · · · · ·
Trinity			FL.	34655
CITY			STATE	ZIP CODE
(727) 834-4000				
TELEPHONE	řΛx		***************************************	
DEPARTMENT NAME				

PLEASE EXPLAIN TERMINATED AFFILIATION:

DEPARTMENT DIRECTOR LAST NAME

01/2010

Active

DEPARTMENT DIRECTOR FIRST NAME & M.I.

12/2012

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

AFFILIATION END DATE

3088

FULL, UNRESTRICTED PRIVILEGES?

 \star REQUIRED RESPONSE NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOWARD

ARE PRIVILEGES

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?

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Section 6	* REQUIRED RESPONSE NO RESPON								
Professional Liability	MAG Mutual	SELF-INSUREDS. YES X NO							
Insurance	CARRIER OR SELF-INSURED NAME		,						
Carrier	8345 Gunn Hwy								
IMPORTANT: IF YOU DO NOT CARRY	Tampa	FL STATE/CO	United States	33626 FOSTAL CODE*					
MALPRACTICE INSUPANCE, CHECK THIS BOX AND SHP THIS SECTION	02/2012	04/2012	04/2013 EXPIRATION DATE	TYPE OF COYERA GE?	X INDIVIOUAL SHARED				
	DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?"	YES X NO	\$1,000,000.00		,000.00				
	POLICY INCLUDES TAIL COVERAGE?	YES X NO							
	PSL160036713		MALE LANGE CONTRACTOR						
Professional Liability	CARRIER OR SÉLF-INSUREO NAME			. Made and the second s	SELF-INBURED? YES NO				
Carrier List other current,	ADDRESS"			ALLE ALLE ALLE ALLE ALLE ALLE ALLE ALLE					
future, or previous cerrier(s) if current cerrier is less that ten 10) years.	cm		STATE/COO	жтят	POSTAL CODE"				
NOTE: A longer period may be required by your healthcare entity.	ORIGINAL EFFECTIVE DATE:	EFFECTIVE DATE	EXPIRATION DAYS	TYPE OF COVERAGE	,, INDIVIDUAL SNARED				
If you have additional Insuernce, use the Supplemental	DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?"	YES NO	AMOUNT OF COVERAGE PER OCC	URRENCE AMOUNT OF	COVERAGE A GOREGA TE				
Insurance Form on page 31.	POLICY INCLUDES THE COVERAGE?	YES NO							
	FOLICY NUMBER								
Section 7	Work History and Refe	rences							
Military Duty	Are you currently on active military duty or military reserve?"	yes 🗶 NO							
Work History	WORK HISTORY								
tectude a chronological work history for the past 10 years.	ACCESS HEALTH CARE PHYSICIANS LLC PRACTICE / PMPL CYER NAME								
A longer period may be required by your healthcare entity.	5350 Spring Hill Dr.								
ifyou have additional work history, use the Supplemental Work History Form on page 32.	Spring Hill		FL	And Administration of the Control of	34606 POSTAL CODE*				
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* REQUIRED RESPONSE, NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

 \star REQUIRED RESPONSE, NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOWUP.

Section 7	Work History and Reference	es (Continue	:d)			
Work History Do not list current positions. Those	(352) 688-8116		(352) 686-5	9477		
should be listed in Section 4.	United States	07/2011		PRESENT		
Include a chronological work history for the past 10 years.	COUNTRY REASON FOR DEPARTURE (F APPLICABLE)	START DATE		END DATE		
A longer period may be required by your healthcare entity	4400-yaka Adalahada Adalah		aneres a service a constitutive of the 1444			
If you have additional work history, use the Supplemental Work History Form on page 32.	WORK HISTORY Access Healthcare, LLC PRACTICE / EMPLOYER NAME					
	5350 Spring Hill Dr.					
	Spring Hill				FL.	34606
	¢(TY				STATE	POSTAL CODE
	(352) 688-8116 TELEPHONE		(352) 686-	9477		
	United States	06/2001		06/2011		
	COUNTRY	START DATE		END DATE		
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	WORK HISTORY					
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	COUNTRY REASON FOR DEPARTURE (IF APPLICABLE)	START DATE	**************************************	END DATE	NI-PAT-PI-ARAKAMANANIA	

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★ REQUIRED RESPONSE NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE POLLOW-UP

Section 7	Work History and References (Contin	ued)			
Gaps in Professional / Work History	Please explain any time periods or gaps in training or y Longer than three months in Buration or of a Shorter	YORK HISTORY THAT HAVI DURATION IF REGULAED S	E OCCURRED S Y THE ORGANI	INCE GRADUATION FROM PROFESSI TATION FOR WHICH YOU ARE BEING	ONAL SCHOOL AND ARE CREDENTIALED.
Work History	GAP START DATE: GAP	END BATE;			
If you have additional professional / work history gaps, use the Supplemental		······································			
Professional Work History Gaps Form on page 33.					
Professional References	Pierre			THE RESERVE OF THE PARTY OF THE	ATTICIONE TO BE THE THE THIRD THE
Provide three professional references					MD
to whom you are not	Jude Antoine PIRST NAME				MD PROVIDER TYPE (MD, ETC.)
related or are not partners in your practice.	5290 Applegate Drive				and the street of the street o
Code lists are found on pages 36-43. Enter the	Spring Hill		FL	United States	3 <i>4</i> 606
associated 3-digit cods - for provider type.	CITY	***************************************	STATE/COU		POSTAL CODE
Note:	(352) 686-3101	(352) 688-8	713		
You are required to provide exactly 3	TELEPHONE	FAX		The state of the s	
references. Your application will not be	Alingu				
complete without this information.	LAST NAME.				
	Alfred				MD PROVIDER TYPE (MD, ETC
Please check with credentialing entity for any special requirements.	10045 Cortez Bivd. Suite 122				
	ADDRESS"				
	Brooksville		FL.	United States	34613 POSTAL CODE ¹
	CITY*		3121200	NIAT	1 92 WE 9882
	(352) 596-0405 TELEPHONE	FAX			
	Benson		- Market Market Control		
	LAST NAME				
	Dalton FIRST NAME				MD PROVIDER TYPE (MO, ETC
	13911 Lakeshore Blvd Suite 111				MANAGEMENT TRANSPORTED TO THE
	ADDRESS*		FL	United States	34667
	Hudson		STATE/COL		POSTAL CODE
	(727) 869-8800 TELEPHONE	(727) 869-8	814		
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* REQUIRED RESPONSE, NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

kaivas karas arakaikai kaltin bali karkaika kalkelakii kalkaika karakaika kalkaikaika ka kalkaikaikai kalkaika Section 8 Disclosure Questions LICENSURE Disclosure Questions Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily refinquished, YES 🗶 NO denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any con-Answer all questions. ditions or limitations by any state or professional licensing, registration or certification board? For any "Yes" response, provide an YES 🗶 NO. Has there been any challenge to your licensure, registration or certification? explanation on the Supplemental Disclosure Question HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS Explanation Form on Have your clinical privileges or medical stell membership at any hospital or healthcare institution, voluntarity or involuntarity, ever page 34. been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee. Allied Health or governing board? Providers: YES 🗶 NO. Have you voluntarily or involuntarily surrondered, limited your privileges or not reapplied for privileges while under invostigation?* if you are en Alked Health Provider and you do not believe a Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, question is applicable by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? to you, you should answer the question EDUCATION, TRAINING AND BOARD CERTIFICATION 'NO". Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimended, suspended or eaked to resign? NO Have you over, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?" YES 🗶 No. Have any of your board contincations or eligibility ever been revoked?" YES 🗶 NO. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challarged, denied, suspended, revoked, restricted, denied renewel, or voluntarily or involuntarily relinquished?" MEDICARE, NEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?" OTHER SANCTIONS OR INVESTIGATIONS Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, educa-YES X NO tion or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offence or sexual misconduct?" To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?* Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? Have you ever been convicted of, pled guilty to, pled note contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct? Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or health care facility of any military agency?* PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

3092

individual liability history?

carrier, based on your individual liability history?"

* REGUIRED RESPONSE NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REGUIRE FOIL OWAR

Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your

Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance

18.

Section 8

Disclosure Questions (Continued)

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on pago 34.

IMPORTANT:

if you answered "Yes" to question #19, you must complete the Supplemental Malpractice Claims Explanation Form on page 35 for each malpractice claim.

MALPRACTICE CLAIMS HISTORY

18. X YES NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or Bilgated) within the past 10 years?*

If yes, provide information for each case.

CRIMINAL/CIVIL HISTORY

YES 🗶 No. Have you ever been convicted of, pled guilty to, or pled noto contendere to any felony?"

in the past ten years have you been convicted of, pied guilty to, or pied noto contenders to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offence or sexual

YES 🗶 NO. Have you ever been court-martialed for actions related to your duties as a medical professional?"

Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.

ABILITY TO PERFORM JOB

Are you currently engaged in the illegal use of drugs?" ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to Indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of

prescription controlled substances.)

YES X NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?"

Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?"

YES 🗶 NO Are you unable to perform the essential functions of a prectitioner in your area of practice even with reasonable

3093

Provider:

Pariksith Singh, MD

Provider CAQH ID:

10721240

Date Generated:

01/22/2013

Last Attestation Date: 01/22/2013

List of Authorized Plans

Blue Cross and Blue Shield of Florida / Health Options, Inc., CIGNA / Great-West Healthcare, Comprehensive Health Management, Inc., Global TPA, LLC, Humana/ChoiceCare, United Healthcare, Universal Health Care, Inc.

AND to any healthcare organization that in the future represents to CAQH either that I am a participating provider or that I am in the process of being credentialed as a participating provider.

Note: Please refer to the online Universal Credentialing DataSoure for the most current version.

Professional IDs Supplemental Form

Section 1	Personal Information and Professional II			<u>Pir palados Para valuros musi bo inicida minicidad (com</u>
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ubmit as instructed.	CDS CERTIFICATE NUMBER		COS ISSUE DATÉ:	
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* REQUIRED RESPONSE (IF THIS PAGE IS USED), NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOWUP.

Other Training Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED), NO RESPONSE MAY CAUSE PROCESSING DÉLAYS AND RÉQUIRE FOLLOWAIP Section 2 Education and Training Training All India Institute of Medical Services AFFILIATED MEDICAL SCHOOL List eli postgraduate training programs you All India Institute of Medical Services attended. Use one INSTITUTION HOSPITAL NAME (USE BOTH LINES IF REQUIRED) section per institution. 29 Aurobindo Marg Ansari Nagar If you need to report auditional Training, 11029 New Delhi photocopy this page as POSTAL CODE needed and submit as STATE instructed. India Code lists are found on TELEPHONE COUNTRY pages 36-43. Enter the DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? associated 3-digit code YËS NO OF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.) in the space provided. List each INTERMSHIP! 06/1972 06/1973 RESIDENCY department FELLOWSHIP OTHER soperatoly, R START DATE END DATE ennlikethe ist Indecreature Ophthalmology "Residency." DEPARTMENT/SPECIALTY (DO NOT A BUREVIATE) llowship an Citizen programs NAME OF DIRECTOR separately AFFICIATED MEDICAL SCHOOL INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED) ADDRESS STATE POSTAL CODE CITY FAX COUNTRY TELEPHONE DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? Yës NO (IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.) iust each department FELLOWSHIP OTHER RESIDENCY separately, if START DATE STAC CM3 aldepilgas List Internatio Residency. DEPARTMENTISPECIALTY (DO NOT ABBREVIATE) eliowstaip and Other programs NAME OF DIRECTOR separately

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Section 4	Practice Location Inform	ation - Page 1 of 5		aladany kaominina dia 4	DANGER TO SEE PHACK SHARK
Additional Practice	LOCATION* # 2				
Location	CURRENTLY PRACTICING AT THIS ADDRESS?* X YES NO	PREVIOUS OR FUTURE 07/01/2011 START DATE?			
IMPORTANT:	ACCESS HEALTH CAR	RE PHYSICIANS LLC			
In the box provided, indicate to which		FEAR IN DIRECTORY (DO NOT AGBREVIATE)			
practice location this page belongs.	ACCESS HEALTH CAR				
For example, if you prectice at three locations, the primary	GROUP / CORPORATE NAME AS IT APPEARS 15120 COUNTY LINE R	ON W-D, IF DIFFERENT FROM ABOVE (DO NOT ABBI RD STE 101	REVIATE)		
location is reported in the main application	ADDRESS				
and remaining locations would be	SPRING HILL				34610
reported on Supplemental Forms	CiTY		·	STATE 7	IF CODE
as Location 2 and Location 3.	SEND GRIEFAL CORRESPON- DENGE HERE?" YES X NO	(727) 378-8588 TELEPHONE	<u>(727) 8</u>	357-5991	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
TIP: Your Individual	OFFICE E-MAIL ADDRESS				
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or Business Office Contact	LASTNAME"				***************************************
List each contact	Diane				
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Section 4	Practice Location Information - Page 3	o r 5		Balling (1997) (1997) (1998) (1997) (1997) (1997) (1997) Balling (1997) (1997) (1997) (1997) (1997)
Additional Practice	LOCATION # 2			
Location (Centinued)	Do Mid-Level, practitioners (nurse practitioners, physician assistants, etc.) care for patients in your practice?*	X YES NO		
IMPORTANT:	(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)			
practice location this page belongs.	Lowenstein			
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* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP Section 4 Practice Location Information - Page 4 of 5 Additional LOCATION* # 2 Practice Location LANGUAGES (Centinued) NON-ENGLISH LANGUAGES
SPOKEN BY OFFICE PERSONNEL: Hindi Italian Greek Gujarati IMPORTANT: LANGUAGE 1 LANGUAGE 2 LANGUAGES LANGUAGE 4 LANGUAGE 6 In the box provided INTERPRETERS LANGUAGES Indicate to which INTERPRETED practice location this LANGUAGE 2 LANGUAGE 3 LANGUAGE 4 LANGUAGE 1 page belongs. Accessibilities DOES THIS OFFICE MEET AGA ACCESSIBILITY REQUIREMENTS?" X YEE NO ACCESSIBLE DY DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING: DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?" PUBLIC TRANSPORTATION? 出さ 白じに ひいりゅう TEXT TELEPHONY (TTY) AMERICAN SIGN LANGUAGE* SUBWAY PARIONG? MENTAUPHYSICAL IMPAIRMENT REGIONAL TRAINS #EHVICES" Taxi OTHER TRANSPORTATION ACCESS OTHER HANDICAPPED A CCESS OTHER DISABILITY SERVICES Services Does this location provide any of the following services? IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM LABORATORY X YES NO (E.G., CLIA, GOLA, MLE): RADIOLOGY IF YES, PROVIDE X-RAY SERVICES? ROUTINE OFFICE ALLERGY INJECTIONS? ALLERGY SKIN EKGS? 🗶 YES X YES NO GYNECOLOGY X YES TESTING? (PELVICIPAP)? TYMPANOMETR DRAWING FLEXIBLE 110 APPROPRIATE X ∷no Y/ AUDIOMETRY SIGMOTO OSCOPY? ASTHMA CARDIA C OSTEOPATIKO IV HYDRATION TREATMENT? STRESS TESTS MANIPULATIONS TREATMENT? PULMONARY PHYSICAL CARE OF MINOR 🗶 YES FUNCTION TESTING? YËS THERAPY? IF YES, WHAT CLASSICATEGORY IS ANESTHESIA YES 🗶 NO ADMINISTERED IN DO YOU USE? YOUR OFFICE? IF YES, WHO ADMINISTERS IT? NAME TYPE OF PRACTICE: X MULTI-SPECIALTY GROUP SOLO PRACTICE SINGLE SPECIALTY GROUP (SELECT ONE ONLY)" SERVICES (Continued) ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES):

* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOWUP Section 4 Practice Location Information • Page 5 of 5 Additional LOCATION* # 2 Practice Location LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE (Continued) IMPORTANT: SCUNZIANO MD Internal Medicine SPECIALTY COVERING LASTNAME In the box provided, COLLEAGUE (YN)? indicate to which MD practice location this MARIA page balongs. PROVIDER TYPE (MD. ETC.) ML FIRST NAME If you have additional pertners/associates et THIS location, use the SPECIALTY COVERING LASTNAME Partner/Associate COLLEAGUE Supplemental Form on page 23. Photocopy as necessary. Be certain M.I. PROVIDER TYPE (MD. ETC.) FIRST NAME to indicate the Practice Location Number at the top of the page. Code lists are found on SPECIALTY LASTNAME COLLEAGUE pages 36-43. Enter the associated 3 digit code in the space provided. PROVIDER TYPE (MD, ETC.) FIRST NAME .. SPECIALTY COVERING LASTNAME COLLEAGUE (YIN)? M.L PROVIDER TYPE (MD, ETC.) FIRST NAME LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE Covering Colleagues SPECIALTY LASTNAWE Code lists are found on pages 36-43. Etter the associated 3-digit code PROVIDER TYPE (MD, ETC.) FIRST NAME in the space provided. If you have additional covering colleagues that are not partners at SPECIALTY LASTNAME this location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as PROVIDER TYPE (MD, ETC.) FIRST NAME necessary. Be certain to Indicate the Practice Location Number at the top of the page. SPECIALTY LASTNAME PROVIDER TYPE (MO, ETC.) FIRST NAME **SPECIALTY** LASTNAME PROVIDER TYPE (MO. ETC.) FIRST NAME 3104

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Section 4	Practice Location Inform	ation - Page 1 of 5		
Additional Practice Location	CURRENTLY PRACTICING AT THIS ADDRESS?	PREVIOUS OR FUTURE 07/01/2011 START DATE?		
IMPORTANT:	ACCESS HEALTH CAR	RE PHYSICIANS LLC		
in the box provided, indicate to which practice location this page belongs.	PHYSICIAN GROUP / PRACTICE NAME TO AP	· · · · · · · · · · · · · · · · · · ·		
For example, if you practice at three locations, the primary	GROUP I CORPORATE NAME AS ITAPPEARS 3480 DELTONA BLVD	ON W-8, IF DIFFERENT PROMABOVE (DO NOT ABBREVIATE))	
location is reported in the main application and remaining locations would be	SPRING HILL		FL 3	4606
reported on Supplemental Forms as Location 2 and Location 3.	SEND GENERAL YES X NO DENCE HERE?	(352) 600-7900 TELEPHONE	(352) 600-8994	CODE
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Office Manager or Business	Burrkhardt			
Office Contact	Diane			
List each contact separately. You may use the check boxes	FIRST NAME & M.I."		· · · · · · · · · · · · · · · · · · ·	
below for convenience. Do not write instructions like "see	(352) 688-8116 TELEPHONE	(352) 686-9477	- Mary Anna Anna Anna Anna Anna Anna Anna Ann	
above". These responses will be rejected and will	dburkhardt@accesshe	althcarellc.net		
Billing Contact		, , , , , , , , , , , , , , , , , , , 		
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Section 4	Practice Location Information - Page 3 of 5			
Additional Practice	- LOCATION* # 3			
Location (Continued)	DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?	(Yes No		
IMPORTANT: In this box provided, indicate to which	(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)	AAAA		***************************************
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Section 4	Practice Location Informat	tion - Page 5 of 5			raga Arjanjanski Vijeto (2017)
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* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOWAUP.

Section 5	* PEQUIRED RESPONSE OF THIS P. Hospital Affiliations		ATTER STREET,	Open Silving in Santana Santana Santana		Aleksania (h. 1916) Aleksania (h. 1916)
Hospital	OTHER HOSPITAL	A TOTAL STREET, A PROPERTY OF THE STREET, A			en, yanger perpenualah dari dari	
Privileges	1					
Use this form to	HealthSouth Rehat	ilitation Hospital	of Spring Hill			
continue listing	HOSPITAL NAME					
hospitals where you currently have	12440 Cortez Boule	∍vard				
privileges.	ADDRESS					
If you need to report	Brooksville			<i>F</i> -	L 34	613
additional space for Hospital Privilages,	CITY				STATE ZIP C	DOE
photocopy this page as	(352) 592-4250					
needed and submit #\$ instructed.	TELEPHONE	•	ΑX	111111111111111111111111111111111111111		
	DEPARTMENT NAME		***************************************			
TIP: Be certain your						
admission percentages add up to 100% for	DEPARTMENT DIRECTOR LAST NAME					
current hospitals.	}					
Otherwise, you will have to correct this	DEPARTMENT DIRECTOR FIRST NAM	ε a M.I.				
впог.	1		Man 4 4441444	12121 211111		
	08/2010	08/2012	PULL, UNRESTRICTED PRIVILEGES?	X YES NO	ARE PRIVILEGES TEMPORARY?	VES 🗶 NO
	AFFILIATION START DAYE	""AFFILIATION END DATE				
7	Active			OF YOUR TOTA ADM#SIGNS, V	YHAT PERCENTAGE	%
	ADMITTING PRIVILEGE STATUS (E.G. I	YONE, FULL (AVRESTRICTED) PRO	VISIONAL, TEMPORARY)	IS TO THIS HO	SPITAL?	
	PLEASE EXPLAIN TERMINATED AFFILIATION:					
	EMMINISTED AFFICIATION.					
		THIS SPACE F	IAS BEEN PURPOSELY LE	FT BLANK		
İ		Security Communication Communi		THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER.		
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	* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY	CAUSE PROCESSING DELAYS AND REQUIRE	FOLLOW-UP				
Section 5			Ale Personal March				
Hospital Privileges	отнек ноspital. Columbia Regional Medical Ctr						
Jae this form to	NOSPITAL HAME 14000 Fivay Road ADDRESS						
continue listing nospitals where you currently have							
privileges.	Hudson		FL.	34667			
If you need to report additional space for Hospital Privileges, photocopy this page as needed and submit as instructed.	(813) 863-2411 TELEPHONE FAX		STATE	ZIP CODE			
	DEFARTMENT NAME			**************************************			
TIP: Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.	DEPARTMENT DIRECTOR LAST NAME:						
	DEPARTMENT DIRECTOR FIRST NAME & M.I.			, sac.			
	08/2007 AFFILIATION START DATE AFFILIATION END DATE	FULL, UNRESTRICTED X YES NO PRIVILEGES?	ARE PR TEMPO	IVILEGES YES X NO			
		OF YOUR TOTAL ANNUAL					
	Active Admitting privilege status (e.g. none, full unrestricted, provision)	1.00 00.00 00.00	NS, WHAT PERCE HOSPITAL?	NYAGE %			
	PLEASE EXPLAIN TERMINATED AFFILIATION:		***************************************				
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Malpractice Claims Explanation Supplemental Form

			RESPONSE MAY CAUSE PROCESSING	DELAYS AND REQUIRE FOLLOW	V-UF.	
ection 8	Malpractice Cla	ims Explanation				
laipractice laims xplanation	DATE OF OCCURRENCE: 04/0	8/2003	Date qam Was filed":	09/03/2003		
e this form to report y "Yes" response to sclosure Question	OPEN X CI	if Case is pending, selec .Osed	T OPEN): IF SETTLED, ENTER OATE CLAIM WAS SETTLED:		***************************************	
19. I you need additional pace to explain a Yes esponse, photocopy nis page as needed nd submit as nstructed.	MAG Mutual PROFESSIONAL LIABILITY CARRIER INVOLVED" (USE BOTH LINES IF NECESSARY) 3525 Pledmont Rd Ste 600					
	Atlanta City			GA SYATE	30305	
	(727) 823-2188 TELEPHONE	<u> </u>	PSL 16003			
	\$240,000.00 AMOUNT OF AWARD OR	GETTLEMENT	METHOD OF RESOLUTION?* DISMISSED	FFOR JUDGMENT FOR	MEDIATION ARBITRATIO	
	DESCRIPTION OF ALLEGAT	TIONS" (USE ALL FOUR LINES	former and	Accountable		

	WERE YOU THE PRIMARY DEFENDANT OR CO-DEFENDANT? PRIMARY DEFENDANT CO-DEFENDANTS (IF ANY): 1					
	YOUR INVOLVEMENT IN CA Primary Care Physician	SE" (ATYENDING, CONSULTIN				
	DESCRIPTION OF ALLEGED INJURY TO THE PATIENT" (USE ALL FOUR LINES BELOW, IF NECESSARY): ITERATORIES					
	***************************************	***************************************				
	THE STREET OF TH	, and a second				
	Did the alleged injury Result in Death?	YES NO	TO THE BEST OF YOUR KNO IN THE NATIONAL PRACTITIO	oner data bank (NPDB)?' Mredge, 19 the Case included	X AES NO	
			3110			

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Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinatter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies that Provider Application (hereinatter, each healthcare organization on the "List of Authorized Organizations" is individually referred to set the "Entity"), and any of the Entity's affiliated extitles, if an required to provide sufficient and accounts information for a proper evaluation of the receive ficensure, relevant training and/or experience, circled competence, the cath status, character, either, and any other criticis used by the Entity for determining initial and engoing eligibility for Participation. Each Entity and its representatives, employees, and appendix) acknowledge that the information obtained relating to the application process with be held confidential to the extent permitted by law.

I authowiedge that each Belly has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation, i authorize the following individuals including, without limitation, the Entity's efficiency of professional conductions, and/or designated agents; and the Entity's designated organization (collectively referred to as "Agenta"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation, I agree to allow the Entity and/or its Agenta) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Refease Information Concerning Application for Participation. I authorize any third party, including, but not limited to individuals, agencies, medical groups reoperable for cradentials verification, corporations, compenies, employers, former employers, hospitals, health plant, hospitals maintenance organizations, menaged care organizations, inwarrance compenies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of Strite Modical Boards, the National Protection Data Bank, and the Health Care Integrity and Protection Data Bank, to refease to the Entity and/or its Agent(x), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quetty assurance and utilization data, character, mental condition, physical condition, alcohol or character, dependency diagnosis and treatment, ethics, behavior, or any other motiter reasonably having a bening on my qualifications for Padicipation in, or with the Entity, I authorize my current end past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me, i specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Refease.

Authorization of Release and Exchange of Disciplinary Information, I hereby further authorize any third perty at which I currently have Participation or hed Participation and/or each third party's agents to telease "Disciplinary Information," as defined below, to the Entity author its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary information and the laparticipating Entities at which I have Participation, and as may be otherwise required by faw. As used herein, "Disciplinary Information' recent Information concerning (I) any extinct latent by such heath care organizations, their administrators, or their medical or other committees to revoke, dany, suspend, restrict, or condition my Participation or impose a corrective action plan; (II) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemptated and/or were for are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and with-out malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Affestation and Release. If urther agree not to sue any Entity, any Agent(s), or any other third party for their octs, defamation or any other claims besed on statements mede in good faith and without matice or releconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be its addition to, and in no way shall limit, any other applicable (manuficial party include their respective employees, directors, officers, edvisors, coursel, and agents. The Entity or any of its affiliates or agents retains the dight to allow excess to the application information for purposes of a credentialing audit to customer and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of cureont if law or regulation limits the application of this irrevocable authorization, I understand that my feiture to promptly provide another consent may be grounds for reventation of decipiline by the Entity in accordance with the applicable or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I cartify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licemes. DEA, insurance, material changes to the information (including any changes/challenges to licemes. DEA insurance, material changes to the information (including any changes/challenges to licemes. DEA insurance, materials) in the process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by my (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and to produce adequate and tilnely information for esolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application my constitute grounds for withdrawal of the explication from consideration; deniel or revocation of Participation; and/or immediate asspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have access to the bytiwe of application, Attestation and Release shall be as effective as the original.

Pariksith Singh, M.D.

Signature*

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