|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DEMOGRAPHICS** | | | | | | | | | | | |
| Last Name First Name M.I. Date | | | | | | | | | | | |
| Title |  | | Maiden Name | | |  |  |  | |  | |
| Home Address | | | | | | | Apartment/Unit # | | |  | |
| City State ZIP County | | | | | | | | | | | |
| Home Phone Home Fax Mobile | | | | | | | | | | | |
| Soc Sec No. Sex Marital Status Time at Present Address | | | | | | | | | | | |
| Spouse | | | | | | | | | | | |
| Email Address Drivers License | | | | | | | | | | | |
| Other Legal Names You Have Used | | | | |  | | | | | | |
|  | | | | | | | | | | | |
| **BIRTH INFORMATION** | | | | | | | | | | | |
| Birth Date Birth County | | | | | | | | | | | |
| Birth Country Birth City Birth State | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **CITIZENSHIP** | | | | | | | | | | | |
| Are You A Citizen of The United States? YES NO If No, Are You Authorized To Work In YES NO The U.S.? | | | | | | | | | | | |
| Visa Number | |  | |  | | Type of Visa | | |  | |  |
| Visa Sponsor | |  | |  | | Visa Status | | |  | |  |
| Visa Expiration | |  | |  | | Green Card Number | | |  | |  |
| National Identification Number | |  | |  | | Country of Issue | | |  | |  |
|  | | | | | | | | | | | |
| **LANGUAGES** | | | | | | | | | | | |
| Foreign Languages You Are Fluent In (in order of proficiency) | | | | | | | | | | | |
| Language 1) Language 2) | | | | | | | | | | | |
| Language 3) | | | | | Language 4) | | | | | | |
| Do You Communicate In American Sign Language? | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **MILITARY SERVICE INFORMATION** | | | | | | | | | | | |
| Military Branch Start Date Discharge Date | | | | | | | | | | | |
| Rank at Discharge | | | | | | Type of Discharge | | | | | |
| If Other Than Honorable, Explain | | | | | | | | | | | |
| Present Duty Status/ Assignment Reserve Status I have No Military Obligation | | | | | | | | | | | |
| **PUBLIC HEALTH SERVICE** | | | | | | | | | | | |

Have You Performed Public Health

Service? YES NO

|  |  |  |  |
| --- | --- | --- | --- |
| If Yes, Please Answer The Following: | | | |
| Beginning Date | | | |
| Ending Date | | | |
| Last Location | | | |
|  | | | |
| **PROFESSIONAL IDENTIFICATION NUMBERS** | | | |
| State License No. License Type | | | |
| License Status | | License State | |
| Current Practice State | | Original Issue Date | |
| Expiration Date | | Current Issue Date | |
| License in Good Standing? YES NO | | | |
| If License Relinquished, Date | | | |
|  | | | |
| **DEA INFORMATION** | | | |
| DEA Number State | | | |
| Issue Date | | Expiration Date | |
| Schedules | | | |
| License In Good Standing | | | |
| Limited or Restricted | | | |
| Explain Restriction | | | |
| Do You Have A State Controlled Substance Registration Certificate? | | | |
|  | | | |
| **MEDICARE & MEDICAID** | | | |
| Medicare Approved YES NO Medicare Number | | | |
| Medicaid Approved YES NO | Medicaid Number | | State Issue  Date |
| Any sanctions imposed by Medicare/Medicaid YES NO | | | |
|  | | | |
| **OTHER IDENTIFICATION NUMBERS** | | | |
| NPI Number | | | |
| CAQH Number | | | |
| UPIN Number | | | |
| **EDUCATION HISTORY** | | | |
| Are You a Foreign Medical Graduate YES NO | | | |

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| --- | --- |
| ECFMG Issue Date | |
| Are You Currently An Intern YES NO Are You Currently A Resident YES NO | |
| Resident Facility Name | |
| Primary Practicing Degree Are You Current with CME’s? YES NO | |
|  |  |
| Professional School Name | |
| Affiliated University/Hospital | |
| Street Address | |
| City State ZIP Country | |
| Phone Number | Fax Number |
| Professional School Start Date | Professional School End Date |
| Education Completed at this  School? YES NO | Degree |
| Department | Specialty |
| Contact Person | |
| Phone Number Fax Number | |
| E-mail Address | |
|  | |
| Professional School Name | |
| Affiliated University/Hospital | |
| Street Address | |
| City State ZIP Country | |
| Phone Number | Fax Number |
| Professional School Start Date | Professional School End Date |
| Education Completed at this  School? YES NO | Degree |
| Department | Specialty |
| Contact Person | |
| Phone Number Fax Number | |
| Email Address | |
|  | |
| **RESIDENCY/INTERNSHIP** | |
| Primary or Secondary | |
| University Affiliation for Residency | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Type of Residency/Fellowship | | | | | | | |
| Program Name | | | | | | | |
| Preceptor/Chairman Title | | | | | | | |
| Honors | | | | | | | |
| Start Date (MM/YY) End Date (MM/YY) | | | | | | | |
| **RESIDENCY/INTERNSHIP** | | | | | | | |
| Primary or Secondary | | | | | | | |
| University Affiliation for Residency | | | | | | | |
| City State | | | | | | | |
| Type of Residency/Fellowship | | | | | | | |
| Program Name | | | | | | | |
| Preceptor /Chairman Title | | | | | | | |
| Honors | | | |  | | | |
| Start Date (MM/YY) | | | | End Date (MM/YY) | | | |
|  | | | |  | | | |
| **SPECIALTY INFORMATION** | | | |  | | | |
| Primary Specialty | | | | Board Certified YES NO | | | |
| Primary Specialty Initial Certification Date | | | | Last Recertification Date (if applicable) | | | |
| Expiration Date | | | |  | | | |
| Name of Certifying Board | | | |  | | | |
| Reason Not Taking Boards | | | |  | | | |
| Do You Have A Secondary Specialty YES NO | | | | Board Certified YES NO | | | |
| Secondary Specialty Initial Certification Date | | | | Last Recertification Date (if Applicable) | | | |
| Reason For Not Taking Boards | | | |  | | | |
| Do You Have Any Additional Specialties YES NO | | | |  | | | |
|  | | | |  | | | |
| **PRACTICE INFORMATION** | | | | | | | |
| PCP Specialist ARNP PA Other | | | | | | | |
| Physician Group/Practice Name (as it appears on the W9) | | | | | | | |
| Primary Office Address | | | | | | | |
| Office Phone No. Office Fax No. | | | | | | | |
| Office Manager E-Mail Address | | | | | | | |
| **PRACTICE INFORMATION CONTINUED** | | | | | | | |
| Tax ID No. Is This The Primary Tax ID for This Location YES NO | | | | | | | |
| Office Hours | | | | | | | |
| SUN | MON | TUES | WED | | THURS | FRI | SAT |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| AM - PM | AM - PM | AM - PM | AM - PM | | AM - PM | AM - PM | AM - PM |
| Patient Age Limitation (list ages seen) Type of Practice | | | | | | | |
| Secondary Office Address | | | | | | | |
| Office Phone No. Office Fax No. | | | | | | | |
| Office Manager E-Mail Address | | | | | | | |
| Tax ID No. Is This The Primary Tax ID for This Location YES NO | | | | | | | |
| Office Hours | | | | | | | |
| SUN | MON | TUES | WED | | THURS | FRI | SAT |
| AM - PM | AM - PM | AM - PM | AM - PM | | AM - PM | AM - PM | AM - PM |
| Patient Age Limitation (list ages seen) Type of Practice | | | | | | | |
|  | | | | | | | |
| **COVERING PHYSICIAN** | | | | | | | |
| Physician Name | | | | | | | |
| Address | | | | | | | |
| Phone Number | | | | | | | |
|  | | | | | | | |
| **PROFESSIONAL LIABILITY INSURANCE INFORMATION** | | | | | | | |
| Carrier Name | | | | | | | |
| Address | | | | | | | |
| Phone Number | | | | | | | |
| Policy No. Original Effective Date Expiration Date | | | | | | | |
| Have You Ever Been Denied Professional Liability Insurance? YES NO | | | | | | | |
| If YES, Insurance Carrier | | | | Denial Date | | | |
| Denial Reason **Attach Claim History** | | | | | | | |
| **WORKERS COMPENSATION INFORMATION** | | | | | | | |
| License Number Issue Date | | | | | | | |
| Certification Status | | | | Expiration Date | | | |
|  | | | | | | | |
| **HOSPITAL PRIVILEGE INFORMATION** | | | | | | | |
| Do You Have Hospital  Privileges? YES NO | | | | | | | |
| Primary Hospital Name | | | | | | | |
| Street Address | | | | | | | |
| City State ZIP County | | | | | | | |

|  |  |  |
| --- | --- | --- |
| Contact Person | Phone No. Fax No. | |
| E-Mail Address | Specialty |  |
| Department Chief | Chief of Staff | |
| Full Unrestricted Privileges YES NO |  | |
| Admitting Privilege Status (e.g. None, Full & Unrestricted, Provisional, Restricted, Temporary) |  | |
| Secondary Hospital Name | | |
| Street Address | | |
| City State ZIP County | | |
| Phone Number | Fax Number | |
| Contact Person | Phone No. Fax No. | |
| E-Mail Address | Specialty | |
| Department Chief | Chief of Staff | |
| Full Unrestricted Privileges YES NO |  | |
| Admitting Privilege Status (e.g. None, Full & Unrestricted, Provisional, Restricted, Temporary) |  | |
|  |  | |
| **WORK HISTORY INFORMATION** | | |
| **Please List Work History For The Past 5 Years. Include Month/Year Format For Each** | | |
| **Current Practice /Employer Name** | | |
| Street Address | | |
| City State ZIP County | | |
| Phone Number Fax Number | | |
| Start Date | End Date | |
| Department | | |
| Supervisor Name Title | | |
| Reason For Departure | May We Contact Employer YES NO | |
| **Practice/Employer Name** | | |
| Street Address | | |
| City State ZIP County | | |
| Phone Number Fax Number | | |
| Start Date | End Date | |
| Department | | |

|  |  |  |
| --- | --- | --- |
| Reason For Departure | May We Contact Employer YES NO | |
| **Practice/Employer Name** | | |
| Street Address | | |
| City State ZIP County | | |
| Phone Number Fax Number | | |
| Start Date | End Date | |
| Department | | |
| Supervisor Name Title | | |
| Reason For Departure May We Contact Employer YES NO | | |
| **Practice/Employer Name** | | |
| Street Address | | |
| City State ZIP County | | |
| Phone Number Fax Number | | |
| Start Date | End Date | |
| Department | | |
| Supervisor Name Title | | |
| Reason For Departure | May We Contact Employer YES NO | |
| **WORK GAP HISTORY** | | |
| Please Explain Any Work Gaps of 6 Months or Longer | | |
|  | | |
|  | | |
|  | | |
|  | | |
|  | | |
| **REFERENCE INFORMATION** | | |
| Please list three professional references. | | |
| **Full Name** Relationship | | |
| Street Address | | |
| Phone Number Fax Number | | |
| E-Mail Address | | Specialty |
| Degree | | Board Certified? |
| **Full Name** Relationship | | |

|  |  |
| --- | --- |
| Phone Number Fax Number | |
| E-Mail Address | Specialty |
| Degree | Board Certified? |
| **Full Name** | Relationship |
| Street Address | |
| Phone Number Fax Number | |
| E-Mail Address | Specialty |
| Degree | Board Certified? |
|  | |
| **PROFESSIONAL AFFILIATION** | |
| Organization Name | |
| Start Date End Date | |
| Position Office Held | Member/Applicant |
|  | |
| Organization Name | |
| Start Date End Date | |
| Position Office Held | Member /Applicant |
|  | |
| Organization Name | |
| Start Date End Date | |
| Position Office Held | Member/Applicant |

**PROVIDER ATTESTATION**

Do you have any physical or mental health problems that may

1)

affect your ability to provide health care? YES NO

Do you have any history of chemical dependency/substance

2)

abuse? YES NO

3) Do you have a history of loss of license and/or felony convictions? YES NO

**PROVIDER PROFILE REPORT**

Do you have any history of loss of limitation of privileges or

4)

disciplinary activity? YES NO

**DISCLAIMER AND SIGNATURE**

I certify that to the best of my knowledge, the information provided on this application is true and complete. I

understand that false or misleading information may result in my release.

Signature Date