



Maine Physician Application

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GENERAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____ Degree _____ Social Security Number _____

Gender* (optional) Female Male

Other Surname Used _____

* Data will be used for consumer information purposes only

Date of Birth _____ Place of Birth _____
City / State/ Country

If not a US citizen, are you eligible to work lawfully in the United States? Yes No

Home Address	Street or PO Box	County
	City/State/Zip	Home Phone <input type="checkbox"/> Unlisted, do not publish
Primary Office Address, in Maine	Office or Group Name	County
	Street or PO Box	Phone
	City/State/Zip	FAX
Mailing Address, if different	Street or PO Box	
	City/State/Zip	
Other Office	Office or Group Name	County
	Street or PO Box	Phone
	City/State/Zip	FAX

If additional space is needed, please use a separate sheet of paper.

E-mail Address	If you would like to receive business communications via e-mail, please PRINT a legible e-mail address.

SPECIALTY/BOARD CERTIFICATION

Specialty designation:

Primary (in which you spend 50% or more of your time): _____ Secondary: _____

Do you have clinical privileges at any hospital in the specialty noted? Yes No

Specialty Board	Initial Certification Date	Date of Last Recertification	Expiration date

If you are not currently Board certified, are you pursuing certification? Yes No

If yes:	If no:
Name of Board:	Do you have postgraduate training sufficient to meet the requirements of a specialty board? <input type="checkbox"/> Yes <input type="checkbox"/> No
Expected Date of Completion:	Please explain reason(s) for not pursuing certification on a separate sheet, including any unsuccessful attempts.

UNDERGRADUATE EDUCATION

Institution	Degree Awarded	Dates Attended FROM-TO (Mo/Yr)
Address	City/State/Zip	Graduation date: Mo/Yr

MEDICAL EDUCATION

Institution	Degree Awarded	Dates Attended FROM-TO (Mo/Yr)
Address	City/State/Zip	Graduation date: Mo/Yr
(Foreign Graduates Only): ECFMG Certification Number and Date:		

GRADUATE EDUCATION

Institution	Degree Awarded	Dates Attended FROM-TO (Mo/Yr)
Address	City/State/Zip	Graduation date: Mo/Yr

INTERNSHIP		
Institution		Dates Attended FROM-TO (Mo/Yr)
Address	City/State/Zip	Specialty
Program Director: Please list current director if different and known.		

RESIDENCIES		
Institution		Dates Attended FROM-TO (Mo/Yr)
Address	City/State/Zip	Specialty
Program Director: Please list current director if different and known.		
Institution		Dates Attended FROM-TO (Mo/Yr)
Address	City/State/Zip	Specialty
Program Director: Please list current director if different and known.		

FELLOWSHIPS		
Institution		Dates Attended FROM-TO (Mo/Yr)
Address	City/State/Zip	Specialty
Program Director: Please list current director if different and known.		
Institution		Dates Attended FROM-TO (Mo/Yr)
Address	City/State/Zip	Specialty
Program Director: Please list current director if different and known.		

If additional space is needed, please use a separate sheet of paper.

HOSPITAL AFFILIATIONS

List chronologically (most recent first) all current and previous hospitals where you hold or have held medical staff membership and/or clinical privileges, beginning with your PRIMARY hospital. If you need additional space, please use a separate sheet of paper.

Institution	Department/Service	Position/Staff Category
Address	City/State/Zip	Dates: FROM-TO (Mo/Yr)
Institution	Department/Service	Position/Staff Category
Address	City/State/Zip	Dates: FROM-TO (Mo/Yr)
Institution	Department/Service	Position/Staff Category
Address	City/State/Zip	Dates: FROM-TO (Mo/Yr)
Institution	Department/Service	Position/Staff Category
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Address	City/State/Zip	Dates: FROM-TO (Mo/Yr)
Institution	Department/Service	Position/Staff Category
Address	City/State/Zip	Dates: FROM-TO (Mo/Yr)
Institution	Department/Service	Position/Staff Category
Address	City/State/Zip	Dates: FROM-TO (Mo/Yr)
Institution	Department/Service	Position/Staff Category
Address	City/State/Zip	Dates: FROM-TO (Mo/Yr)

WORK HISTORY

List chronologically (most recent first) all professional activities, paid or volunteer, including employment, self-employment, service as an independent contractor and military service and all healthcare entities other than the hospitals listed on page 4 where you now hold or have held clinical privileges. **DO NOT** duplicate internship, residency, or fellowship information previously reported. If you need additional space, please use a separate sheet of paper.

ANY GAP OF GREATER THAN 60 DAYS IN CHRONOLOGY REQUIRES EXPLANATION.

Organization		Title/Position
Address	City/State/Zip	Dates: FROM-TO (Mo/Yr)
Organization		Title/Position
Address	City/State/Zip	Dates: FROM-TO (Mo/Yr)
Organization		Title/Position
Address	City/State/Zip	Dates: FROM-TO (Mo/Yr)
Organization		Title/Position
Address	City/State/Zip	Dates: FROM-TO (Mo/Yr)
Organization		Title/Position
Address	City/State/Zip	Dates: FROM-TO (Mo/Yr)
Organization		Title/Position
Address	City/State/Zip	Dates: FROM-TO (Mo/Yr)
Organization		Title/Position
Address	City/State/Zip	Dates: FROM-TO (Mo/Yr)
Organization		Title/Position
Address	City/State/Zip	Dates: FROM-TO (Mo/Yr)

REFERENCES

Please provide names and complete addresses of four (4) professional references. These individuals must have personal knowledge through direct observation of your current clinical abilities, ethical character, and ability to work with others. References should be individuals other than your partners or business associates. If you currently hold hospital privileges, one reference must be from your current department chief. If you are currently completing a residency or fellowship, one reference must be from residency/fellowship director, as appropriate.

Name	Phone	Fax
Address		City/State/Zip
In what capacity has this individual observed your clinical abilities: Current Department Chief or Residency/Fellowship Director		
Name	Phone	Fax
Address		City/State/Zip
In what capacity has this individual observed your clinical abilities:		
Name	Phone	Fax
Address		City/State/Zip
In what capacity has this individual observed your clinical abilities:		
Name	Phone	Fax
Address		City/State/Zip
In what capacity has this individual observed your clinical abilities:		

HEALTH INFORMATION

Your application will be processed in the usual manner regardless of how you answer questions 1 and 2. If you have answered "NO" to question 1 or 2, please explain completely on a separate sheet of paper. If you are found to be qualified, a representative will contact you to determine what accommodations are necessary and feasible to allow you to practice safely.

1. Are you physically and mentally able to perform all the essential functions or services necessary to exercise the privileges or services applied for with or without a reasonable accommodation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you able to perform these functions without significant risk of injury to yourself or others?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you currently engaged in the illegal use of drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature _____

Date _____

LICENSING-LIST ALL CURRENT AND PAST LICENSES

STATE	TYPE	LICENSE NO.	DATE ISSUED	EXPIRATION DATE	STATUS
MAINE					

If the answer is "YES" to any of the following questions, please provide details on separate sheet of paper.

1. Have you ever had your license to practice medicine in any state or other jurisdiction involuntarily or voluntarily restricted, suspended, revoked, denied, made subject to probationary conditions, or otherwise disciplined?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are any proceedings which could result in such action currently pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever voluntarily withdrawn an application, resigned your license or permitted it to lapse?	<input type="checkbox"/> Yes <input type="checkbox"/> No

DEA REGISTRATION

Federal DEA Registration No. _____ Date Issued _____ Expiration Date _____

If applicable, please list additional:

Federal DEA Registration No. _____ Date Issued _____ Expiration Date _____

If the answer is "YES" to any of the following questions, please provide details on separate sheet of paper.

1. Have you ever been denied registration by the U.S. Drug Enforcement Administration (DEA) or has your registration ever been modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked your state permit to prescribe or dispense controlled substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are any proceedings which could result in such action currently pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever voluntarily withdrawn your narcotics application, resigned your registration or permitted it to lapse?	<input type="checkbox"/> Yes <input type="checkbox"/> No

ID NUMBERS

NPI/UPIN# _____ Not applicable Medicare # _____ Not applicable
 Medicaid # _____ Not applicable

Do you have financial relationship (ownership or compensation arrangement) in a hospital, clinical lab, home health agency, nursing home, DME supplier, pharmacy, radiology, emergency department or any other medically related organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, please provide details of financial relationship-terms of arrangement, % of ownership, other principals, lawyers, officers, services provided, sites, etc.

PROFESSIONAL LIABILITY

If the answer is "YES" to any of the following questions, please explain on a separate sheet of paper.

1. Have you ever practiced medicine without liability coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been denied professional liability insurance or has your policy ever been canceled or denied renewal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have any restrictions ever been placed on your liability insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever had an insurance carrier add a surcharge to your malpractice policy or increase your deductible?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If the answer is "YES" to any of the following questions, please complete a Malpractice Claims/Suit History (Page 10) for each event.

5. Have you <i>ever</i> received a notice of claim ¹ or been a defendant in a medical malpractice suit rising out of or in connection with your individual professional services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Are you aware of any such notice of claims against another person or entity rising out of or in connection with your individual professional services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you or your malpractice carrier or any other person or entity made an out-of-court settlement or paid a judgment on a professional liability claim on your behalf or on behalf of any other person or entity rising out of or in connection with your individual professional services in the past 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No

¹ Notice of claim is defined as a written communication from a claimant or plaintiff setting forth an allegation of professional malpractice, threatening or initiating legal action, and demanding money damages.

INSURANCE CARRIERS

List chronologically (CURRENT Carrier first) ALL insurance companies, hospitals, clinics or employers who have provided professional liability coverage. If you need additional space, please use a separate sheet of paper. If there is any gap in the chronology, please explain.

Current insurance carrier	Initial policy date	Current expiration date
Address	City/State/Zip	
Coverage amounts (incident/aggregate)	Policy Number	
Previous carrier	Initial policy date	Expiration Date
Address	City/State/Zip	
	Policy Number	
Previous carrier	Initial policy date	Expiration Date
Address	City/State/Zip	
	Policy Number	

ADDITIONAL INFORMATION

If the answer is "YES" to any of the following questions, please explain on a separate sheet of paper and include a copy of any order or settlement where applicable. All questions and their subparts must be answered.

1. Have you ever had your clinical privileges or employment at any hospital or any other health care facility limited, suspended, revoked, not renewed or made subject to probationary conditions or otherwise adversely affected?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1a. Are such proceedings currently pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever had a request for any specific clinical privilege(s) denied as a result of disciplinary action or granted only with stated limitations (aside from ordinary initial probationary requirements of proctorship)? For purposes of this question, voluntary withdrawal does not constitute denial.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2a. Are such proceedings currently pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever had hospital (or similar health care institution) privileges that had previously been granted to you suspended, restricted or withdrawn involuntarily?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever voluntarily surrendered or modified your privileges or resigned from medical staff membership?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever had your medical staff membership or status on the staff of any hospital or other health care facility limited, suspended, revoked, not renewed or made subject to probationary conditions or otherwise adversely affected?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5a. Are such proceedings currently pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been denied membership on any hospital medical staff or been denied advancements in medical staff status?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Is there currently pending against you any litigation, investigatory or disciplinary proceeding with respect to privileges, licensure, DEA or other criminal or administrative matter (including PRO sanctions) or civil matter initiated by the government?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation or otherwise sanctioned, by any health care organization, including but not limited to, hospitals, or other health care facilities, based on professional competence?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation or otherwise sanctioned by HMOs, PPOs, physician hospital organization (PHO), independent practitioner association (IPA) professional associations or societies, professional standards review organization (PSRO) or peer review organization (PRO), based on professional competence?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you ever been excluded, suspended or otherwise sanctioned by Medicare or Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10a. Are such proceedings currently pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you ever been disciplined by a professional society or resigned while allegations were pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you ever been convicted in a criminal proceeding or been subject to an adverse government agency administrative decision (including PRO sanctions), been subject to an adverse decision in any civil litigation brought by a government agency, entered a plea of nolo contendere, or been subject to an adverse settlement in any such proceeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Have you ever been convicted of any criminal offense (including motor vehicle offenses but not including minor traffic or parking violation)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13a. Are such proceedings currently pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No

MALPRACTICE CLAIMS/SUIT HISTORY

PLEASE COPY THIS FORM FOR EACH ADDITIONAL CLAIM/SUIT

NO CLAIMS: Please sign and date at bottom

Date of Alleged Incident: _____ Date Lawsuit Filed: _____

Name of Court and Case Number: _____

Please Explain Nature of Allegations of Wrongdoing/Negligence: _____

Status of Case: (with reference to you specifically)

- Notice of Claim Filed: As of _____ Date
- Pending Before Malpractice Panel: As of _____ Date
- Pending in Court: As of _____ Date
- Closed Without Payment: Date _____
- Pre-Trial Settlement (\$ _____)- As of _____ Date
- Verdict for Defendant: As of _____ Date
- Verdict for Plaintiff (\$ _____)- As of _____ Date

What was/is your status:

- Sole Defendant
- Co-Defendant with _____
- Other: _____

I understand information submitted herein becomes part of my Application for staff appointment/credentialing and may also be used in future recredentialing.

Signature

Date

MANAGED CARE SUPPLEMENT

This supplement must be completed only if you are submitting an application to a health plan, managed care organization, physician network or physician-hospital organization.

Check the status for which you are applying:

Primary Care Physician Only Specialty Care Physician Only Primary and Specialty Care Physician

I want to participate as this specialty : Primary _____ Secondary: _____

Do you regularly use a hospital emergency room for coverage of your patients (other than for emergency care)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you admit patients to the hospital under your own service?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you provide treatment to workers' compensation patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you practice family medicine, do you provide obstetrical care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you limit the age of patients you treat?	<input type="checkbox"/> Yes _____ min/max <input type="checkbox"/> No
Will you accept new patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No (Practice limited to existing pts.)
Do your facilities provide parking for the handicapped?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are your facilities wheelchair accessible?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your office multilingual? If yes, which language(s)? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your office employ a physician assistant, nurse practitioner or nurse midwife for direct care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Please check all that apply: <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Nurse Midwife Please submit any applicable plan of supervision if a PA, NP or CNM is employed in the office.	

Services you provide: Do you routinely provide the following services directly for your patients?

Routine Office Visits	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pap Smears	<input type="checkbox"/> Yes <input type="checkbox"/> No
In-Hospital Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodic Physical Exams	<input type="checkbox"/> Yes <input type="checkbox"/> No
Immunizations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prevention Care and Education	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your business telephone have an answering service/machine that is accessible at all times when you are not in the office?			<input type="checkbox"/> Yes <input type="checkbox"/> No
What arrangements do you have for 24 hour coverage for your patients when you are unavailable?			
Identify physicians in your coverage group.			
Please indicate instructions given to patients relating to after hours access to your office.			
List the name of the hospital(s) in Maine where you currently hold or have applied for staff privileges.			

MANAGED CARE SUPPLEMENT CONTINUED

What days and hours are you available to see patients in your office?			What days and hours is your office open and staffed to see patients?		
	FROM	TO		FROM	TO
Monday			Monday		
Tuesday			Tuesday		
Wednesday			Wednesday		
Thursday			Thursday		
Friday			Friday		
Saturday			Saturday		
Sunday			Sunday		

Office Manager/Contact: _____

Credentialing Contact: _____

Please check type of practice: Individual Employee Partnership Office Sharing Corporation Group

Name of Individual or Corporation that should appear on reimbursement check

Street or PO Box City/State/Zip

Tax ID used at this address: _____

This Tax ID# is a- Federal Tax Identification No. Social Security No. Group ID No.

If you use more than one Tax ID number, please submit an IRS W-9 form for each.

REFERENCES

If the references listed on page 6 were not managed care participating physicians, please list two (2) physicians who are participating with a managed care organization.

Name	Phone	Fax
Address	City/State/Zip	
Name	Phone	Fax
Address	City/State/Zip	

I understand information submitted herein becomes part of my Application for participating with the Plan.

Signature Date