STATE OF ILLINOIS

Health Care Professional Credentialing and Business Data Gathering Form

The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that this form be collected from health care professionals by hospitals, health care entities, and health care pl

ATTACHMENTS

Attach forms A-F as needed to support "yes" responses in Section J: Professional History and copies of the following:

Curriculum Vitae	
CONFIDENTIAL INFORMATION	

CHAPTER A: PRACTICE AND PROFESSIONAL INFORMATION

SECTION B. PROFESSIONAL INFORMATION					
Illinois Professional License N	Illinois Professional License Number:				
License Unlimited?	Yes □	No 🗌	If No, please explain limitation:		
Current and Previous Professional License(s) in Other States State:					

National Provider Identification	Number (NPI):		
Medicaid ID#:			
X-Ray Certification: State:	Certificate #:	Expiration Date:	(mm/dd/yy)
Check here if you have appended	l additional information fo	r this section:	

SECTION C. PROFESSIONAL LIABILITY INSURANCE

Please provide information on all professional liability insurance carriers from whom you have received coverage in the past $10~{\rm years}$.

CURRENT PROFESSIONAL LIA	BILITY INSURANCE	
CONFIDENTIAL INFORMATION:		
Carrier:		
Address:	~	O
Street	City	State Zip
Policy Number:	Original Effective Date: (mm/dd/yy)	Expiration Date: (mm/dd/yy)
Policy Limits: Per Occurrence: \$	Aggregate: \$	(),
Retroactive Date:		
(mm/dd/yy) What type of coverage do you have?	☐ Claims Made ☐ Occurrence	ā
Has any judgment or payment of claim of		
,, , , , ,		∐ Yes ☐ No
PREVIOUS PROFESSIONAL LIA	ABILITY INSURANCE	
CONFIDENTIAL INFORMATION:		
Carrier:		
Address:		
Street	City	State Zip
Policy Number:	Original Effective Date: (mm/dd/yy)	Expiration Date: (mm/dd/yy)
Policy Limits: Per Occurrence: \$	Aggregate: \$	(
Retroactive Date: (mm/dd/yy)	☐ Claims Made ☐ Occurrence	
What type of coverage do you have? Has any judgment or payment of claim of		
ary judgman or paymon or dame	Strick arroad a decoded the ripayi	

SECTION D. EDUCATION AND TRAINING

If there are any gaps in your training (greater than 30 days), or if you have not completed any portion of your training, please explain on a separate sheet of paper and attach to this application.

MEDICAL/PROFESSION	AL SCHOOL		
Institution Name:			
Mailing Address:			
Street		City	State Zip
Telephone Number: ()	Fax Number: ()	<u> </u>	·
Degree:Y	ear Graduated:		
Dates attended: From: mm/yy If you are a graduate of a forei Medical Graduates (ECFMG)?		iified by the Education	al Commission for Foreigr
Date I ssued:	Serial Number for E	CFMG:	
	any disciplinary action during y	our attendance at this ir	nstitution? Tyes Tyo
,	anation of a "Yes" answer.)		
If you attended more than one duplicates the information reques		olease check here and	attach an explanation that
INTERNSHIP			
Institution Name:			
Department Chair or Program Di	rector:		
	Last Name	First Name	MI Degree
Mailing Address:			
Street		City	State Zip
Telephone Number: ()	Fax Number: ()		
Dates attended: From:	To:		

FIRST RESIDENCY			
Institution Name:			
Department Chair or Program Director:			
Last Name	First Name	MI	Degree
Mailing Address:			
Street	City	State	Zip
Telephone Number: () Fax Number: ()			
Dates attended: From: To: mm/yy mm/yy			
Type of residency:			
Did you successfully complete this program? ☐ Yes ☐ No —	→ If no, please at	tach an expl	anation.
Were you the subject of any disciplinary action during your attenda	ance at this institution?	☐ Yes	□No
(Attach an explanation of a "Yes" answer.) ◄			
`			
SECOND RESIDENCY			
Institution Name:			
Department Chair or Program Director:			
Last Name	First Name	MI	Degree
Mailing Address: Street	City	State	Zip
	•	Otato	Δip
Telephone Number: () Fax Number: ()			
Dates attended: From: To: mm/yy mm/yy			
Type of residency:			
Did you successfully complete this program? Yes No-	→ If no. please at	ach an expl	anation.
Were you the subject of any disciplinary action during your attenda	•		□No
(Attach an explanation of a "Yes" answer.)			
If more than two residencies, please check here and attach additional		icatos tha in	oformation
requested above:	а ппоппапоп пагорі	ivates the If	II OITHAUOH

(Please continue next page)

		I

TEACHING EXPERIENCE/FACULTY APPOINTMENT (MOST RECENT) Institution Name: Department Chair or Program Director: First Name Last Name Degree Mailing Address: City Street Zip Telephone Number: () Fax Number: () Rank/Position, if applicable: Dates: Were you the subject of any disciplinary action during your attendance at this institution? ☐ No (Attach an explanation of a "Yes" answer.) TEACHING EXPERIENCE/FACULTY APPOINTMENT (PREVIOUS) Institution Name: Department Chair or Program Director: First Name Degree Mailing Address: State City Zip Telephone Number: () Fax Number: () Rank/Position, if applicable: Dates: (Attach an explanation of a "Yes" answer.) If more than two teaching experiences/faculty appointments, please check here and attach additional information that duplicates the information requested above: (Please continue next page)

. 01	ther Hospital	
	Hospital Name:	
	A ddroog	
	Street	City State Zip
	Membership Status:	Dates:To:To:To (mm/yy)
	Department/Division:	Medical Staff Office FAX #: ()
	Department Telephone #: ()	
	Any Limitations in Your Area of Specialty at this	s Hospital?
ıecl	k here if you have appended additional information	on for this section:
	SECTION F. HOSPITAL M	IEMBERSHIP – PREVIOUS
	Internship/Residency/Fellowship. Use the Me	usly held privileges other than during your embership Status key listed prior to Section E.
H		embership Status key listed prior to Section E. bitals.)
H	Internship/Residency/Fellowship. Use the Mo (Include additional sheets if more than three hospotal Name: Address:	embership Status key listed prior to Section E. Ditals.)
H	Internship/Residency/Fellowship. Use the Mo (Include additional sheets if more than three hosp Iospital Name: Address: Street	embership Status key listed prior to Section E. bitals.) City State Zip
H	Internship/Residency/Fellowship. Use the Mo (Include additional sheets if more than three hospotal Name: Address:	embership Status key listed prior to Section E. bitals.) City State Zip
H	Internship/Residency/Fellowship. Use the Mo (Include additional sheets if more than three hosp Iospital Name: Address: Street Membership Status:	City State Zip Dates: To: From (mm/yy) To (mm/yy)
H	Internship/Residency/Fellowship. Use the Mo (Include additional sheets if more than three hosp Iospital Name: Address: Street Membership Status: Department/Division:	City State Zip Dates: To: From (mm/yy) To (mm/yy)
H	Internship/Residency/Fellowship. Use the Mo (Include additional sheets if more than three hosp Include additional sheets if more than three hosp Include additional sheets if more than three hosp Include additional sheets if more than three hosp Includes Include additional sheets if more than three hosp Includes Inclu	City State Zip Dates: To: To (mm/yy) Medical Staff Office FAX #: ()
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	Internship/Residency/Fellowship. Use the Mo (Include additional sheets if more than three host Include	City State Zip Dates: To: From (mm/yy) To (mm/yy) Medical Staff Office FAX #: ()
	Internship/Residency/Fellowship. Use the Mo (Include additional sheets if more than three hosp Include additional sheets if more than three hosp Include additional sheets if more than three hosp Include additional sheets if more than three hosp Includes Include additional sheets if more than three hosp Includes Includes Includes Includes Included Includes Included Includes Includes Includes Included Includes Inclu	City State Zip Dates: To: From (mm/yy) To (mm/yy) Medical Staff Office FAX #: ()
	Internship/Residency/Fellowship. Use the Mo (Include additional sheets if more than three host Include	City State Zip Dates: To: From (mm/yy) To (mm/yy) Medical Staff Office FAX #: ()
	Internship/Residency/Fellowship. Use the Mo (Include additional sheets if more than three host Include Include additional sheets if more than three host Include Inc	City State Zip Dates: To: From (mm/yy) To (mm/yy) Medical Staff Office FAX #: () City State Zip To: From (mm/yy) To (mm/yy) Medical Staff Office FAX #: ()
	Internship/Residency/Fellowship. Use the Mo (Include additional sheets if more than three hose) Iospital Name: Street Membership Status: Department/Division: Department Telephone #: () Any Limitations in Your Area of Specialty at this Iospital Name: Address: Street Membership Status:	City State Zip Dates: To (mm/yy) Medical Staff Office FAX #: () State Zip To (mm/yy) Medical Staff Office FAX #: () City State Zip To (mm/yy) State Zip To (mm/yy) To (mm/yy) To (mm/yy) To (mm/yy)
	Internship/Residency/Fellowship. Use the Mo (Include additional sheets if more than three host Include	City State Zip Dates: To: From (mm/yy) To (mm/yy) Medical Staff Office FAX #: () City State Zip To: From (mm/yy) To (mm/yy) SHospital? City State Zip Dates: To: From (mm/yy) To (mm/yy) Medical Staff Office FAX #: ()

C.	Hospital Name:

SECTION H. WORK HISTORY

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

Current work place:		
Address:		
Street	City	State Zip
Telephone: () Fax Number: ()		
Title or Professional Occupation:		
Time in this employment: From: to Present (mm/yy)		
Previous work place:		
Address:		
Street	City	State Zip
Telephone: () Fax Number: ()		
Title or Professional Occupation:		
Time in this employment: From: to:		
(mm/yy) (mm/yy)		
Previous work place:		
Address:		
Street	City	State Zip
Telephone: () Fax Number: ()		
Title or Professional Occupation:		
Time in this employment: From: to: (mm/yy)	<u> </u>	
Previous work place:		
Address:		_
Street	City	State Zip
Telephone: () Fax Number: ()		
Title or Professional Occupation:		
Time in this employment: From: to: (mm/yy)	<u> </u>	
Previous work place:		
Address:		
Street	City	State Zip
Telephone: () Fax Number: ()		
Title or Professional Occupation:		
Time in this employment: From: to:		
(mm/yy) (mm/yy)	<u> </u>	

Previous work place:						
Address:						
Street				City	State	Zip
Telephone: () Fax Number						
Title or Professional Occupation:						
Time in this employment: From:		to				
	/vv)		(mm/vv)			
Previous work place:						
Address:				0''		 ,
Street Telephone: () Fax Numbe	or: (\		City	State	Zip
Title or Professional Occupation:						
Time in this employment: From: (mm	v/yy)	10	(mm/yy)			
Previous work place:						
Address:						
Street				City	State	Zip
Telephone: () Fax Number	er: <u>(</u>)				
Title or Professional Occupation:						
Time in this employment: From:		to	:			
(mm	√yy)		(mm/yy)			
Previous work place:						
Address:						
Street				City	State	Zip
Telephone: () Fax Number						
Title or Professional Occupation:						
Time in this employment: From:		to				
(mm	√yy)		(mm/yy)			
Check here if you have appended additional	inforn	nation	for this sec	tion: 🔲		

(Please continue next page)

SECTION I. PROFESSIONAL REFERENCES

Please list the names of three individuals who have personal knowledge (within the past 12 months) of your current clinical abilities, ethical character and interpersonal skills and who would be willing to provide this information upon request. Do not list partners or department chairpersons. Do not list relatives or people listed elsewhere in this credentialing form.

	\					
C	CONFIDENTIAL INFORMAT	ION				
1	Name:				Title:	
1.	Last	First	МІ	Degree	Title.	
	Special(ty0 9 766.7(h.4 T0 Tw()TjJTty0 9 766.7(h.4 T0 5	5n.001u	004 Tc1u004	4 an)Tj/T Tw[Tw[Tw[Tw[m2 6C	4

51860.

SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL

ADVERSE OR OTHER ACTIONS

Submit with all applications. Please answer the following questions to the best of your knowledge with a "yes" or "no." If you answer "yes" to any question(s) please complete Form A. Please make copies of Form A as needed and complete one form for each "yes" answer.

1. Has your license to practice in any jurisd

12.	Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO?	□Yes	□No
13.	Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision?	□Yes	□No
PR	OFESSIONAL LIABILITY ACTIONS		
	f you answer yes to any question(s) in this section please complete FORM B. Please m FORM B if needed, and complete one for each yes answer.	ake copies	of
1.	Have any professional liability judgments ever been entered against you?	☐Yes	□No
2.	Have any professional liability claim settlements ever been paid by you and/or paid on your behalf?	□Yes	□No
3.	Are there any currently pending professional liability suits, actions and/or claims filed against you?	□Yes	□No
4.	Has any person or entity ever been sued for your clinical actions?	☐Yes	□No
LIA	ABILITY INSURANCE		
	If you answer yes to this question please complete FORM C.		
COV	e you ever been denied or voluntarily relinquished your professional liability insurance erage, and/or have had your professional liability insurance coverage canceled, non-wed or limits reduced?	□Yes	□No
CR	IMINAL ACTIONS		
	f you answer yes to any question(s) in this section please complete FORM D. Please FORM D if needed, and complete one for each yes answer.	make copi	es of
1.	Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country?	□Yes	□No
2.	Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse?	□Yes	□No

Health Care Professionals Credentialing $\&\,$ Business Data Gathering Form Applicant Name:

MEDICAL CONDITION		
If you answer yes to this question please complete FORM E. Do you have a medical condition, physical defect or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety?	□Yes	□No
CHEMICAL SUBSTANCES OR ALCOHOL ABUSE If you answer yes to any question(s) in this section please complete FORM F. Please	maka aani	ios of
FORM F if needed, and complete one for each yes answer.	шаке сорг	es oi
1. Are you currently engaged in illegal use of any legal or illegal substances?	□Yes	☐ No
2. Do you currently overuse and/or abuse alcohol or any other controlled substances?	□Yes	☐ No
3. If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety?	□Yes	□No
4. Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse?	□Yes	□No
INVESTMENTS		
In the last five (5) years have you and/or a member of your family purchased or made an investment in (other than securities of a publicly traded company), or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, and/or other business dealing with the provision of ancillary health services, equipment or supplies?	□Yes	□No
If Yes, please provide explanation:		

Health Care Professionals Credentialing $\&\,$ Business Data Gathering Form Applicant Name:

(Please continue next page)

CHAPTER B: BUSINESS INFORMATION

SECTION K. PRIMARY SITE INFORMATION

Please provide the following information for the primary site at which you practice.

Primary	7							
Site		usiness Name						
	Building	Name						
	Office A	ddress – Numb	per and Street – S	uite				
	City			C	County	State	Zip	
	<u>()</u> Main Tel	ephone Numb	er Office A		.ast F	First	МІ	
	(<u>)</u> Beeper N		(<u>)</u> FAX Nu		E-mail			
	_	-	<u>(</u>) Answerii	ng Service				
Specialty	practiced at thi	s site:						
		•	pecialty (e.g., by	•	,	′es □ No		
II yes	, describe the i	estrictions						
Briefly de	scribe your pra	actice at this lo	cation, including	any special prad	ctice focus or ec	quipment:		
Are you c	urrently accept	ing new patien	ts at this location	ı? ∐Yes	□No			
If yes,	describe any r	estrictions (e.g	,, appointment ty	pe, patient type):			
Please pro	vide the numb	er of active pat	tients enrolled wi	th you at this sit	te:			
Please pro	vide the numb	er of patient vi	sits you have at t	his site per year	•			
Indicate appropria	Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
Hours	-	-	-	-	-	-	-	
	to	to	to	to	to	to	to	

Please indicate standard	natient waiting tim	ies to schedule an ai	ppointment at th	is site for:
i icuse illuicute staliaala	patient waiting thi	ics to scirculate all a		is site ioi.

			New Patient	Existin	g Patient	
Emergency Care						
Urgent Care						
Symptomatic Care (e.g., sore throat	t)					
Routine Visits (e.g., blood pressure	check))				
Preventive Routine Care (e.g., school	ol or ar	nnual physical)				
Please provide the following regarding your	r pract	tice at this site:				
Maximum Number of Appointments per H	lour					
Average Waiting Time in Office (from sch	eduled	appointment time	to actual exam	ination)		
Average Response Time for Returning	Acu	ite or Urgent Situa	tion:			
Patient Calls:		ergency Situation:				
		itine Call:				
lease check all procedures you perform at	this si					
Age-appropriate immunizations		□EKG		☐ Drawing blood		
Tympanometry/audiometry screening	g	X-rays		☐ Minor surgery		
☐ Pulmonary function studies		☐ Flexible sigm	., —		eration repair	
Office gynecology (routine pelvic/PA	,	Asthma treatn			gyskin testir	ıg
Osteopathic/Chiropractic manipulati	ion	☐ IV hydration/	treatment	☐ Physic	cal Therapy	
ist any special skills or qualifications you nedicine or treat certain patients or classe uency in a foreign language or proficiency Special Skills of Practitioner:	es of particles of	atients. List sep	arately any sp			
Special Skills of Staff:						
Languages Spoken by Practitioner:						
Languages Written by Practitioner:						
Languages Spoken by Staff:						
Languages Written by Staff:						
s this practice site handicapped accessible	•	all that apply)? ☐ Wheelchair	Restroom			
Ooes this site employ paraprofessionals for	direct	patient care?	☐ Yes ☐	No		
If yes, is supervision always provide ☐	ed on p	oremises during pa	nraprofessionals	direct pat	tient care?	

Lab Service at this site?	☐ Yes ☐ No						
	If yes, check whether: Primary Secondary Tertiary						
CLIA Waiver:	☐ Yes ☐ No						
	If yes, CLIA Expiration Date:						
Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.							
Name: - 25	1 Tw ()Th9n-6.9(ivh7D hA8 Tw (r41c3 r7:3r52651.5(r4						

I		

SECTION M. ADDITIONAL SITE INFORMATION

Please provide the following information for each additional site at which you practice.

Site	7						
#	Group/B	usiness Name					
	Building	Name					
	Office A	ddress – Numb	per and Street – S	uite			
	City			C	County	State	Zip
	<u>(</u>) Main Te	lephone Numb	er Office A	dministrator – L	ast F	First	MI
	(<u>)</u> Beeper N	Number	() FAX Nu	mber	E-mail		
	(<u>)</u> Emerger	ncy Number	<u>(</u>) Answerii	ng Service			
Specialty	practiced at thi	is site:					
	actice restricte s, describe the		pecialty (e.g., by		,	∕es □ No	
Briefly de	scribe your pra	actice at this lo	cation, including	any special prad	ctice focus or ec	quipment:	
-		• .	its at this location		□ No):		
Please pro	ovide the numb	per of active pa	tients enrolled wi	th you at this sit	re:		
			sits you have at t				
	your office s ate spaces for		is location in t	he following t	able. Write	your specific	hours in the
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours							
	to	to	to	to	to	to	to

Please indicate standard patient waiting times to schedule an appointment at this site for:

☐ Pulmonary function studies

☐ Office gynecology (routine pelvic/PAP)☐ Osteopathic /Chiropractic manipulation

				New Patient	Existing Patient
	Emergency Care				
		Urgent Care			
		Symptomatic Care (e.g., sore throat)			
		Routine Visits (e.g., blood pressure check)			
	Preventive Routine Care (e.g., school or annual physical)				
P	lease p	rovide the following regarding your	practice at this site:		
	Maximum Number of Appointments per Hour				
	Average Waiting Time in Office (from scheduled appointment time to actual examination)			nation)	
Average Response Time for Returning Acute or Urgent Situation:		tion:			
	Patier	tient Calls:	Emergency Situation:		
	Routine Call:		Routine Call:		
Please check all procedures you perform at this site:					
	☐ Age-appropriate immunizations ☐ EKG ☐ Tympanometry/audiometry screening ☐ X-rays				

☐ Flexible sigmoidoscopy pped Tw[cessi10.8T1e(si)4:

Lab Service at this site?	☐ Yes ☐ No			
	If yes, check whether: Primary	☐ Secondary	☐ Tertiary	
CLIA Waiver:				

SECTION N. ADDITIONAL SITE TAX INFORMATION

Please provide the following information for each additional site at which you practice. Include tax information for each business arrangement you use at this site. (If there is more than one additional site, or more than five business arrangements at any one site, pl				

FORM A – ADVERSE AND OTHER ACTIONS

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

Applicant Name:	First	MI
200	THO	1411
Indicate the number of ONE of the quest	tions in Section J to which you answered "yes":	Question Number:
A. Describe the circumstances surround	ling this occurrence. Please include the date of	the occurrence.
B. Provi a.		

FORM B – PROFESSIONAL LIABILITY ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name: Last	First	MI
	11134	IVII
A. Plaintiff's Name: Last	First	MI
If court case, Case Name & Case N	lumber:	
B. Your Involvement in the Care (Attending	g, Consulting, Etc.):	
C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.):		
D. Allegations, including Patient Outcome,	if Available:	
E. Date of Incident (mm/yy):	F. Date Filed (mm/yy):	
G. Date Case Closed (mm/yy):		
Resolution Case: Dismissed Settlement out of	Judgment Arbitration of Court Pending Mediation	Other
H. Amount Paid on Your Behalf (if any): \$		
I. Professional Liability Insurer Name (if on	ne was involved):	_
J. Insurer Telephone Number: ()	K. Policy Number:	
L. Insurer Address (Street, City, State, Zip C	Code):	
Signature:	Date:	

FORM C – LIABILITY INSURANCE

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name:					
·	Last	First	MI		

FORM D – CRIMINAL ACTIONS

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

Applicant Name:		
Last	First	MI
A. Date of Incident (mm/yy):		
B. Date of Complaint or Conviction (mm/yy):		
C. Date of Resolution (mm/yy):	<u>_</u>	
D. Type of Resolution (Dismissed, Plea Bargain	n, Misdemeanor, Felony):	
E. Allegation(s):		
F. Details of Incident:		
G. Actions Taken Against You:		
H. Current Status of Situation:		

I. Medical Practice Privileges Affected as

FORM E – MEDICAL CONDITION

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

Applicant Name:						
·	Last	First	MI			

FORM F - CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

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

Applicant Name:		
Last	First	MI
Describe the substance you use:		
A. To what extent does, or could, your use of specialty area or to perform a full range of		ability to practice medicine in your
B. Monitored by State Board Mandate (Nam	ne and Address) C. Monitored Volu	untarily (Name and Address)
D. Other information about the current status	s of your use of substances:	
E. Abstinent since (mm/yy):		
F. Provide the name and address of your persyour treatment for alcohol or chemical sucurrent/future professional practice.		
Name:		
Address:		
Street Telephone: ()	City	State Zip
Signature:		Date: