Office Information: Please list **all** office addresses. Indicate which office is your primary office (only one office can be noted as your Primary Office), and which should be your mailing address. Also, please indicate if this particular address is your administrative, clinical or research office.

Office/Practice Name: _____ Practice Manager Name:_____ Street Address: _____ Street Address: _____	**Office Type:**	**Mailing**

Street: _____ City: _____ State: _____ Zip: _____

Department/Specialty: _____ Dates (Mo/Yr) From: _____ To: _____

Supervisor/Chief/Contact Person: _____ Phone Number: _____

Fellowships: **Include only primary hospital (do not include rotations)**. Attach additional sheet if necessary.

Hospital/Facility: _____

Street: _____ City: _____ State: _____ Zip: _____

Department/Specialty: _____ Dates (Mo/Yr) From: _____ To: _____

Supervisor/Chief/Contact Person: _____ Phone Number: _____

Hospital/Facility: _____

Street: _____ City: _____ State: _____ Zip: _____

Department/Specialty: _____ Dates (Mo/Yr) From: _____ To: _____

Supervisor/Chief/Contact Person: _____ Phone Number: _____

Hospital/Facility: _____

Street: _____ City: _____ State: _____ Zip: _____

Department/Specialty: _____ Dates (Mo/Yr) From: _____

Statement of Continuing Medical Education Credits: (please list the courses taken in the last 24 months. Your education activities should relate, at least in part, to your privileges.)

Course Taken:	Where:	When:	# of CME hours:

Military Commitment:

Branch of Service:	
Duty Status:	
Rank:	
Present Duty Assignments:	
I have no military obligations	

Licensure: Please list all professional licenses that you currently hold or have held in any jurisdiction.

Current Licenses:

Number	State	Expiration Date	Type (full, limited, temporary)

Previous Licenses:

Number	ExState	Expiration Date	Type (full, limited, temporary)

Professional References: Please check with the individual Hospital/Health Plan to which you are applying for specific instructions regarding the submission of Professional References.

Contact Name: _____ Contact Title: _____

Hospital/Facility:_____ Department: _____ Phone Number: (___)_____

Questions regarding licensure and prescriptive privileges:

1.	Have any disciplinary actions** been threatened, initiated or are any pending against you by a state licensure board?	Yes* Ä No Ä
2.	Has your license to practice in any state ever been denied, limited, suspended or revoked, diminished, not renewed, relinquished (whether voluntarily or involuntarily) or are any proceedings currently pending which may result in any such action?	Yes* Ä No Ä
3.	Have your privileges to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, not renewed, surrendered (voluntarily or involuntarily) or have you been called before or warned with regard to these privileges by this state or any jurisdiction or federal agency at any time? Is any such action currently pending?	Yes* Ä No Ä
4.	Have any formal or written complaints been filed against you with any state professional licensing board?	Yes* Ä No Ä
5.	Do you hold a narcotic registration for any other state?	Yes* Ä No Ä

Questions regarding healthcare facility employment and/or privileges:

6.	Has your professional employment ever been suspended, diminished, revoked or terminated at any hospital or healthcare facility or are any proceedings that may result in any such action currently pending?	Yes* Ä No Ä
7.	Has your medical staff appointment/privileges ever been limited, suspended, diminished, revoked, refused/denied, terminated, restricted, not renewed, relinquished (whether voluntarily or involuntarily) at any hospital or healthcare facility or are proceedings currently pending which may result in any such action?	Yes* Ä No Ä
8.	Have you ever withdrawn (or voluntarily relinquished) your application for appointment, re-appointment or privileges or resigned from the medical staff because disciplinary action** or loss or restriction of clinical privileges was threatened or before a decision about your appointment and/or privileges was rendered by a hospital's or healthcare organization's governing board?	Yes* Ä No Ä
9.	Have you ever been the subject of disciplinary action** or proceedings at any healthcare facility?	Yes* Ä No Ä
10.	Have you ever been investigated for scientific misconduct?	Yes* Ä No Ä

Section II – Additional Information

Section III -- Applicant's Authorization and Release

I hereby apply for:

1. Medical/professional staff appointment and clinical privileges as requested herein at each hospital to which I submit this application (Hospital); and
2. Participation as a network or health plan provider with each provider network or health plan to which I submit this application (Health Plan).

I am willing to make myself available for interviews in regard to this application. I also agree to provide each Hospital and Health Plan with updated information regarding all questions on this application form as such information becomes available and such additional information as may be requested by the hospital(s), Health Plan(s) or their respective authorized representatives. I understand that failure to provide all information requested will prevent evaluation of and/or action on my application.

I hereby attest that the information in or attached to this application is true and complete and fairly represents the current level of my training, experience, capability and competence to practice the clinical privileges reques

Applicant's Authorization and Release (cont'd)

acts performed in good faith and without malice in connection with the evaluation of my professional skills, competence, character, credentials and qualifications and the exchange of information with respect to my professional skills, competence, character, credentials a

If you have answered "yes" to any of the questions on the Application, please supply the information requested below. Use a separate copy of this form for **each** question and indicate the number of the question to which you are responding.

Question #_____

PLEASE PRINT OR TYPE RESPONSES

Provider's Name: _____

Medical License Number: _____

Date of Action/Occurrence: _____

Date Claim/Complaint/Criminal Case was filed: _____

Facility Where Incident Occurred: _____

Status of Claim/Complaint/Criminal Care (open, closed including date closed, etc): _____

Duration of Occurrence: _____

Professional Liability Carrier Involved: _____

Amount of Settlement: _____

Method of Resolution:

Ã Dismissed
Ã Judgment for Plaintiff(s)
Ã Settled with Prejudice
Ã Settled without Prejudice
Ã Judgment for Defendant(s)
Ã Mediation or Arbitration
Ã Letter of advice, consent agreement, letter of concern, warning letter, PHS agreement, other (please include a copy)

Date of Settlement/Action Taken: _____

Were you the primary defendant or co-defendant? YES Ã NO Ã

Detailed Description:

MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE
Definition of "Disciplinary Action" (243 CMR 3.02)

(1) An action of any entity, including, but not limited to, a governmental authority, a health care facility, an employer, or a professional medical association (international, national, state or local).

(2) An action that is:
- (a) formal or informal, or
- (b) oral or written (except an oral reprimand or admonition is not a "disciplinary action.")

(3) Any of the following actions on their substantial equivalents, whether voluntary or involuntary:

- (a) Revocation of a right or privilege
- (b) Suspension of a right or privilege
- (c) Censure
- (d) Written reprimand or admonition
- (e) Restriction of a right or privilege
- (f) Non-renewal of a right or privilege
- (g) Fine
- (h) Required performance of public service
- (i) A course of education, training, counseling, or monitoring, only is such course arose out of the filing of a complaint or the filing of any other formal charges reflecting upon the licensee's competence to practice medicine
- (j) Denial of a right or privilege
- (k) Resignation
- (l) Leave of absence
- (m) Withdrawal of an application
- (n) Termination or non-renewal of a contract with a license

Section IV – Payor Enrollment Information

Practice Information and Demographics

Do you wish to be listed as Ä Primary Care Physician Ä Specialist Ä Both

If you are in Internal Medicine, Family Practice, or Pediatrics, but do not maintain a panel of patients, indicate the services

Under what specialty(s) do you want to be listed in the Insurer's Provider Directory(s)? _____

_____

Which age groups do you treat? Ä All ages Ä 0-11 yrs Ä 12-18 yrs Ä 19-25 Ä 26-65 yrs Ä 65+ yrs

List any restrictions on your practice: _____

Length of time it takes for a new patient visit: 1/2 hr. ____ 1 hr. ____ 1 1/2 hrs. ____ 2 hrs. ____ 2 ½+ hrs. ____

What is the average waiting time for a patient to schedule an appointment:

Type of Visit	Waiting Time
Initial visit to establish a relationship with a physician	
Preventative health care visit (routine physical)	
Urgent visit	

What are the average number of visits scheduled per hour? _____

Do you perform laboratory tests in your office? Yes Ä No Ä

Billing Information:

Practice Locations (from page 2 of this application)

Name of Primary Practice:	Name of Secondary Practice:
Phone Number: ( )	Phone Number: ( )

Practice Type: Ä Solo Ä Group Ä Clinic Ä Other

OFFICE PHONE #: _____
OFFICE FAX #: _____

Clinical Practice Office	**NO**
Research Office	

Payment information: Make checks payable to: _____

Payment Address (please provide complete mailing address): _____

Billing entity phone #: _____ IRS Tax ID#: _____

Applies to: Ä Primary Practice Ä Secondary Practice

PLEASE COPY THIS PAGE FOR ADDITIONAL OFFICE LOCATIONS

In the event that the Hospital or Health Plan has any questions about this application, please provide contact information