

Welcome Clinicians!

This form will be used to provide information to the various insurance companies that the Clinic uses for reimbursement. Please fill out the form completely and attach the requested documentation. If you have any questions about the form, please contact Maria Bodner, Assistant Fiscal Director (ext. 256) or John Prins, Director of Human Resources (ext. 208). Thank you.

Today's date

_____ Last name	_____ First name	_____ Middle initial	
_____ Social Security number	_____ Gender	_____ Birth date	Yes No _____ US Citizen (circle one)

If license issued under a name other than the names listed, e.g., maiden name, alias, nicknames, please list below:

Last Name: _____ First Name: _____

Provider Type (e.g. MA, MSW, LCSW, LPC, MD, etc): _____

Are you fluent in any language(s) other than English? Please list:

Practicing Specialty

My primary Practicing Specialty is: (e.g., Couples, families, children, adolescents) _____

My secondary Practicing Specialty is: (e.g., substance abuse, development, trauma, ADD) _____

If you specialize in certain areas, which of the following conditions do you treat?

- _____ Attention Deficit Disorder
- _____ Anxiety Disorder (includes phobias and Obsessive Compulsive Disorder)
- _____ Biofeedback
- _____ Eating Disorders
- _____ Medical Issues (including chronic illnesses such as AIDS or MS)
- _____ Mood Disorders
- _____ Pain Management
- _____ Sexuality Issues (including gay and lesbian issues)
- _____ Thought Disorders (e.g., schizophrenia, dissociative disorder)
- _____ Trauma (e.g., post-traumatic stress, rape, incest)

About Your Credentials
State Licenses/Certificates

Please list all professional licenses or certificates to practice that you've ever held. Then, **attach** copies of all your currently active licenses or certificates. If you need additional space, feel free to attach a separate sheet.

State: _____

State License/Certificate Number: _____

Type (i.e., MD, DO, etc.): _____

Date of Initial State License/Certificate: _____

Expiration of Current State License/Certificate: _____

Is this license/certificate active?

Do you currently practice under it?

Does your license/certification level require supervision?

Federal DEA Certificate For MDs, APRNs, Etc. Please **attach** a copy of your current Federal DEA Certificate(s).

State DEA Certificate Number: _____

Expiration Date: _____

Limited or Restricted? _____

(If Yes, please explain. Attach a separate sheet if necessary.)

Please indicate all schedules currently held:

State Narcotics Registration Please **attach** a copy of your currently active Controlled Dangerous Substances Registrations

STATE: _____

CDS RESISTRATION NUMBER: _____

LIMITED OR RESTRICTED: _____

(If Yes, please explain. Attach a separate sheet if necessary.)

Board Certification Status

For each certification, please indicate your specialty, the certificate number, and the dates of certification and expiration. Please include issuing board (ABMS, AOA, etc.).

Specialty: _____

Original Effective Date: _____

Issuing Board: _____

Expiration Date: _____

Certificate Number: _____

Last Recertification Date: _____

If you haven't received Board Certification, please indicate the specialty in which you practice, and your status in the certification process for that specialty. If you're not eligible for – or not planning to take – specialty boards, please explain:

ABOUT YOUR EDUCATION AND TRAINING

Undergraduate School *Please use the complete school name:* _____

Facility Name: _____

Attendance Dates: _____

Mailing Address: _____

Degree Received: _____

Graduate School and/or Medical School *Please use the complete school name* _____

Facility Name: _____

Attendance Dates: _____

Completed: _____

Mailing Address: _____

Degree Received: _____

Internship/Residency *Please use the official facility name*

Facility Name: _____

Attendance Dates: _____

Completed: _____

Mailing Address: _____

Program Type/Specialty: _____

Facility Name: _____

Attendance Dates: _____

Completed: _____

Mailing Address: _____

Program Type/Specialty: _____

Fellowship *Please use the official facility name*

Facility Name: _____

Attendance Dates: _____

Completed: _____

Mailing Address: _____

Program Type/Specialty: _____

Other Post-Graduate Training

Facility Name: _____

Attendance Dates: _____

Completed: _____

Mailing Address: _____

Program Type/Specialty/Degree Received: _____

This section is to be filled out if you have a practice outside of Clifford W. Beers Guidance Clinic.

About Your Other Practice(s)

Do you currently practice at any address other than the Clifford Beers Clinic?

Legal Practice Name: _____

Tax I.D. Number: _____

Full Address: _____

Office Phone Number: _____

Office Fax Number: _____

E-Mail Address: _____

Languages fluently spoken by office staff in addition to English: _____

Handicapped Access? _____

Office Practice Type: _____

Are you accepting new patients? _____

Are there age limitations on your patients? _____

If yes, please specify age range: **Age** _____

Hours Clinic is open:

Mon	Tue	Wed	Thu	Fri	Sat	Sun
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Professional Liability Insurance (Please attach Prof Liability Ins for any other practice outside of Clifford Beers Clinic)

Additional Insurance Carrier (if you carry any other current additional professional liability insurance, please complete the following section)

ABOUT YOUR COMMUNITY

HOSPITAL PRACTICE INFORMATION:

PROFESSIONAL MEMBERSHIPS AND SOCIETIES

NAME OF ORGANIZATIONS: _____

Conflict of Interest Statement

Do you or any member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, or other business dealing with the provision of ancillary health services, equipment or supplies?

Yes or No If Yes Identify:

Education and Training

1. During your education, internship, residency, fellowship, preceptorship or additional training, as applicable, were you ever disciplined, suspended, placed on probation, formally reprimanded, or asked to resign? YES or NO

Board Certification

1. Has your Specialty Board certification or eligibility ever been denied, revoked, relinquished, not renewed, suspended, or reduced – or have any proceedings toward those ends been instituted? YES or NO

License Information (For the purpose of this application, "state" also includes any district, territory or province.)

1. Have you ever been disciplined, reprimanded, or fined by any state board of medical examiners, professional conduct board, or state or federal agency that disciplines physicians or allied health professionals? YES or NO

2. Has your license to practice, in your profession, ever been denied, limited, suspended, revoked, or subject to probation or any conditions or limitations in any state? YES or NO

3. Have you ever been disciplined, suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health program (for example, Medicare, Medicaid, CLIA), professional society or managed care organization – or is any such action pending? YES or NO

4. Have you ever been the subject of an investigation by any private, federal, or state health program – or is any such action pending? YES or NO

5. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) Certificate(s) ever been voluntarily or q N/A involuntarily limited, suspended, revoked, relinquished, or not renewed – or are proceedings currently pending? YES or NO

Insurance Information

1. Has your professional liability insurance coverage ever been terminated or modified by action of an insurance company? YES or NO

2. Have you ever been denied professional liability insurance coverage or rated in a higher-than-average risk class for your specialty? . YES or NO

3. Have any professional liability suits, actions or claims alleging malpractice ever been filed against you? YES or NO

4. Are any professional liability suits, actions or claims currently pending against you? YES or NO

5. Have any judgments ever been made against you in professional liability cases or claims, or have you ever entered into any settlements? YES or NO

6. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank? YES or NO

7. Are you currently uninsured for professional liability (malpractice insurance) coverage? YES or NO

IMPORTANT: *If any of the following questions is answered "Yes," please attach an explanation for each answer. For your convenience, the Professional Liability Action Explanation Form is included with this application for each explanation of liability actions, or settlements made on your behalf. If you need additional sheets, please photocopy the form. If any questions do not apply to you, please answer "No."*

Hospitals and Other Affiliations

1. Have your clinical privileges at any hospital or healthcare institution or organization ever been limited, suspended, revoked, not renewed, or subject to probationary or other disciplinary conditions, or have proceedings toward any of these ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board YES or NO
2. Has your request for any specific clinical privileges been denied or granted with stated limitations (aside from ordinary or initial requirements of proctorship), or has such a denial or limitation been recommended by a medical staff or peer review committee to a governing board? YES or NO
3. Have you ever had any previous or pending challenges to, or voluntarily or involuntarily relinquished any medical staff membership; clinical privilege(s), as the result of any investigation or disciplinary action? YES or NO
4. Have you ever been court-martialed, sanctioned, reprimanded, or cautioned by a hospital or any other healthcare facility or military agency; been involuntarily terminated or forced to resign; or have you resigned voluntarily while under investigation or threat of sanction from a hospital or healthcare facility or any military agency? YES or NO

Health Status

1. Are you currently using any illegal drugs? YES or NO
2. During the last three years have you ever been under the influence of alcohol during working hours, or have you used drugs illegally? YES or NO
3. Are you unable, with or without reasonable accommodation, to practice to the fullest extent of your license, qualification, and privileges without in any way posing a risk of harm to your patients? YES or NO

Criminal History

1. Have you ever been arrested for, or charged with, a crime involving children? YES or NO
If "Yes," include the disposition of the arrest or charge on a separate sheet. This statement is being answered under penalty of perjury, subject to applicable Federal punishment for perjury.
2. Have you ever been convicted of a felony or are you presently under investigation or have you ever been indicted for a felony? YES or NO

Signature

Date

Please attach: Updated CV and/or resume; copies of all licenses, board certifications, DEA certifications, Substance Abuse Certifications, etc.

Note: If you practice anywhere else, please provide a copy of your professional liability insurance policy page