1. APPLICANT DATA

Name *Last*	*First*	*Middle*	Degree *(MD/DO/DDS)*

Other names used (past or present):

Social Security Number	Sex	DOB	Office Fax Number

Office Address	City	State	Zip	Phone No.
Residence Address	City	State	Zip	Phone No.

Marital Status	Birthplace	Citizenship

If not a U.S. Citizen, what is your residency (VISA) status?	Cell Phone	Would you prefer to have your mail directed to: ○ HOME ○ OFFICE

Basic Life Support Certification ☐ yes - Expiration Date:	Pager	Email
ACLS Certification ☐ yes - Expiration Date:		

2. MEDICAL EDUCATION DATA

Medical School	Address				Degree
	City	State	Zip	Country	Date Started: Date Completed:

If foreign medical school graduate, are you ECFMG certified ○ Yes ○ No If yes, Certificate Number:

INTERNSHIP - Hospital	Address				From (month/year)
Specialty	City	State	Zip	Country	To (month/year)
RESIDENCIES - Hospital	Address				From (month/year)
Specialty	City	State	Zip	Country	To (month/year)
Hospital	Address				From (month/year)
Specialty	City	State	Zip	Country	To (month/year)
Hospital	Address				From (month/year)
Specialty	City	State	Zip	Country	To (month/year)
FELLOWSHIP - Hospital	Address				From (month/year)
Specialty	City	State	Zip	Country	To (month/year)
Hospital	Address				From (month/year)
Specialty	City	State	Zip	Country	To (month/year)

Have you ever been placed on probation or asked to resign an internship or residency training program? ○ Yes ○ No

If yes, please explain fully on an attached sheet of paper.

Please describe below all omissions or discrepancies in chronological order beginning with your medical/dental education through the present (if additional space is needed, please explain fully on an attached sheet of paper)**:**

Time Period	**Description/Explanation**
From (month/year): To (month/year):	
From (month/year): To (month/year):	

3. SPECIALTY/FIELD OF PRACTICE

What is your medical practice specialty?

If you have a subspecialty, please list:

4. PROVISIONAL STAFF STATUS

Provisional status will be assigned to all initial Medical Staff appointments. This initial provisional appointment shall be for a minimum period of one year from the date of initial appointment.

5. BOARD CERTIFICATION DATA

If you are qualified or certified by a Board as recognized by the American Board of Medical Specialties, complete this section.

Complete Name of Board:

☐ Qualified: **Provide date you became qualified/eligible**:	☐ Certified:	Dates of Certification From: To:	Certificate No.:

Complete Name of Board:

☐ Qualified **Provide date you became qualified/eligible:**	☐ Certified:	Dates of Certification: From: To:	Certificate No.:

Complete Name of Board:

☐ Qualified **Provide date you became qualified/eligible:**	☐ Certified:	Dates of Certification: From: To:	Certificate No.:

Have you been recertified?	○ Yes ○ No	**If no**, give reason:
If you are not certified, have you taken a Board Certification Examination and failed:	○ Yes ○ No	**If yes**, please provide details:

6. DEA DATA

DEA (BNDD) No.	Expiration Date

A. Has your DEA Certificate ever been suspended, revoked or limited? ○ Yes ○ No

If yes, please explain fully on an attached sheet of paper.

B. Have you ever voluntarily surrendered your DEA Certificate? ○ Yes ○ No

If yes, please explain:

7. MEDICAL LICENSURE DATA

Please list states in which you have been or presently are licensed to practice medicine.	State	License Number	Expiration Date

A. Has any State Board of Licensure ever filed a complaint against or investigated your licensure status; or are any investigations currently pending? ○ Yes ○ No

If yes, please explain fully on an attached sheet of paper.

B. Has your license to practice medicine in **any** state ever been suspended, revoked, monitored, restricted, or limited in any way? ○ Yes ○ No

If yes, please explain fully on an attached sheet of paper.

C. Have you ever voluntarily surrendered a medical license issued to you? ○ Yes ○ No

If yes, please explain fully on an attached sheet of paper.

8. MEDICAL REIMBURSEMENT PLAN DATA

A. Have you voluntarily or been involuntarily suspended, limited, revoked, denied not renewed or terminated your participation in Medicare, Medicaid or any other medical reimbursement plan for reasons related to professional competence or conduct? **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No
B. Have you ever been or are you currently excluded from participation with Medicare or any other federally funded health care program? **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No

If applicable, please provide the following:

Medicare Number	Medicaid Number	CAQH ID Number and Login	UPIN/NPI Number and Login

9. CLAIMS DATA

A. Has any claim or suit alleging malpractice, judgments or settlements been brought against you in the last 10 years? **If yes**, give complete details on the Section 9 Supplemental (page 10) of this application (one claim per page -- form may be photocopied for additional claims). Report <u>all</u> claims or suits, including those that were dismissed.	○ Yes ○ No
B. To the best of your knowledge, have any incidents occurred in your practice that have any realistic potential of developing into a formal claim against you?	○ Yes ○ No
If yes, have you reported such incidents to your current carrier?	○ Yes ○ No
If yes, please explain fully the incident on an attached sheet of paper.	

10. CURRENT AND PRIOR HOSPITAL AFFILIATIONS

Name **<u>all current and prior</u>** hospital affiliations in chronological order since completion of your medical education (if more space is needed, **please continue on separate sheet of paper**).

HOSPITAL		Address		From (month/year)
Specialty	City	State	Zip Code	To (month/year)
HOSPITAL		Address		From (month/year)
Specialty	City	State	Zip Code	To (month/year)
HOSPITAL		Address		From (month/year)
Specialty	City	State	Zip Code	To (month/year)
HOSPITAL		Address		From (month/year)
Specialty	City	State	Zip Code	To (month/year)
HOSPITAL		Address		From (month/year)
Specialty	City	State	Zip Code	To (month/year)
HOSPITAL		Address		From (month/year)
Specialty	City	State	Zip Code	To (month/year)

A. Have you ever had any medical staff membership or privileges voluntarily or involuntarily refused, denied, revoked, suspended or relinquished by a hospital, license, or registration agency (federal, state, or local) or other professional health care organization or are any challenges to such memberships, privileges, or licenses presently pending? **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No
B. Have you ever appeared before, been investigated by or entered into any consent agreement of any formal hospital committee, state licensing board, Board of Medical Examiners or other medical review committee? **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No
C. Have you ever had a patient file a grievance of any type with a hospital committee or a state medical board? **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No

11. PROFESSIONAL LIABILITY INSURANCE COVERAGE

List your insurance carrier(s) for the past ten years and provide all requested information. *If more space is required, use separate page.*

CARRIER		Limits		From (month/year)
		☐ Claims Made	☐ Occurrence Type	
Address	City	State	Zip	To (month/year)
CARRIER		Limits		From (month/year)
		☐ Claims Made	☐ Occurrence Type	
Address	City	State	Zip	To (month/year)
CARRIER		Limits		From (month/year)
		☐ Claims Made	☐ Occurrence Type	
Address	City	State	Zip	To (month/year)
CARRIER		Limits		From (month/year)
		☐ Claims Made	☐ Occurrence Type	
Address	City	State	Zip	To (month/year)

A. **IMPORTANT NOTE FOR APPLICANTS/EMPLOYEES OF UTP OR UT:** Currently valued loss runs (in addition to professional liability insurance certificates) from your current and all previous professional liability insurance carriers for the past 10 years are required. Please complete a Confidentiality Agreement, Authorization and Release form for Detailed Claim History (Section 11 Supplement, page 11) for each insurance carrier previously listed above and mail it to the carriers. **IT IS YOUR RESPONSIBILITY TO REQUEST THESE LOSS RUN REPORTS.**

B. Have you ever had professional liability insurance declined, cancelled, issued on specific terms or had renewal refused? **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No

12. PRACTICE RELATED DATA

A. Can you perform all of the essential functions of the privileges which you are requesting, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients? **If no**, please explain fully on an attached sheet of paper.	○ Yes ○ No
B. Have you ever been convicted of a violation of a federal, state or local law other than minor traffic violations? **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No
C. Have you had any criminal convictions that have been expunged or sealed from your record? **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No
D. Have you ever been disciplined for a violation of ethical standards by a professional organization? **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No
E. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank? **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No
F. Do you have a history of engaging in the illegal use of drugs? ("Illegal use of drugs" means the use of any controlled substances illegally obtained, i.e. not obtained pursuant to a valid prescription and not taken in accordance with the direction of a licensed health care practitioner.) **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No
G. Are you currently engaged in the illegal use of drugs? ("Currently" does not mean on the day of or even the weeks preceding the completion of its application. Rather, it means recently enough so that the illegal use may have an impact on ones ability to practice.) **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No
H. Are you currently in treatment for addiction to drugs or alcohol? **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No
I. Within the last five years, have you been reprimanded or disciplined in any manner by any state licensing authority or other professional board for conduct related to the use of alcohol or the use of any drug? **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No
J. Do you have any emotional or physical disabilities that may limit your ability to practice? **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No
K. Have you ever been investigated or disciplined for sexual misconduct? **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No
L. Do you or do you plan to engage in moonlighting activity? **If yes**, please explain fully on an attached sheet of paper.	○ Yes ○ No

13. WORK HISTORY

List your places of practice or employers, starting with current positions and going back to the completion of your training. This sheet may be photocopied if more space is needed.

Practice/Employer ______________________________

Contact Name ______________________________

Address/Street ______________________________

City/State/Zip ______________________________

Phone ____________________ Fax ____________________

Dates of Employment Month/Year Started ____________________ Month/Year Ended ____________________

Reason for Leaving ______________________________

____

Practice/Employer ______________________________

Contact Name ______________________________

Address/Street ______________________________

City/State/Zip ______________________________

Phone ____________________ Fax ____________________

Dates of Employment Month/Year Started ____________________ Month/Year Ended ____________________

Reason for Leaving ______________________________

____

Practice/Employer ______________________________

Contact Name ______________________________

Address/Street ______________________________

City/State/Zip ______________________________

Phone ____________________ Fax ____________________

Dates of Employment Month/Year Started ____________________ Month/Year Ended ____________________

Reason for Leaving ______________________________

____

Practice/Employer ______________________________

Contact Name ______________________________

Address/Street ______________________________

City/State/Zip ______________________________

Phone ____________________ Fax ____________________

Dates of Employment Month/Year Started ____________________ Month/Year Ended ____________________

Reason for Leaving ______________________________

____

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14. CURRENT PRACTICE DATA

List any non-clerical support personnel employed by you (or by any group in which you practice) who assist in patient treatment at **The University of Toledo Medical Center** (physician assistant, surgery assistant, CRNA, midwife, nurse practitioner, technician, etc.)

Employee Name	License Number	Certified
Title		Non-Certified
Employee Name	License Number	Certified
Title		Non-Certified
Employee Name	License Number	Certified
Title		Non-Certified

15. REFERENCES

Please list two references from active staff of The University of Toledo Medical Center and/or two references with whom you have had recent significant interaction (such as but not limited to, residency director or Clinical Service Chief of prior hospital) or a peer who is familiar with your current clinical competence.

Name		Division	
Street Address	City	State	Zip Code
Telephone:	Fax:	E-mail:	
Name		Division	
Street Address	City	State	Zip Code
Telephone:	Fax:	E-mail:	
Name		Division	
Street Address	City	State	Zip Code
Telephone:	Fax:	E-mail:	
Name		Division	
Street Address	City	State	Zip Code
Telephone:	Fax:	E-mail:	

16. CONTINUING MEDICAL EDUCATION

I certify that I have fulfilled the required CME requirements needed to maintain an Ohio Medical License (if applicable).

_____ _____

Actual Signature of Physician Date

SERVICE USE ONLY

This application is approved: ☐ not approved: ☐. Status: Provisional ☐

_____ _____

Service Chief Date

Print Form