Initial Allied Health
Provider Application

MedicalDoctor
ASSOCIATES

Dear Provider:

Welcome to locum tenens with Medical Doctor Associates, LLC the quality leader in medical staffing. Please complete and return the enclosed application packet along with copies of the documents listed below.

- **Current Curriculum Vitae** ~ *(the CV must include your work history, from completion of training to the present. All dates must include month & year, and not contain any gaps in time)*
- **All Training Program Diplomas (if Advanced Practice, please provide both RN and Advanced Practice Information)** *(as applicable)*
- **Certification – as applicable** *(Certificate or Letter)*
- **All Active and Inactive State Licenses (if Advanced Practice, please provide both RN and Advanced Practice Information)** *(Wallet Copy)*
- **DEA/CDS Certificates** *(as applicable)*
- **IRS W-9 Form**
- **Advanced Cardiac Life Support (ACLS); Basic Cardiac Life Support (BLCS); Advanced Trauma Life Support (ATLS); Pediatric Advanced Life Support (PALS)** (please include copies of all applicable)
- **Current Certificate of Insurance** *(if not utilizing MDA' s coverage)*
- **National Practitioner Identifier (NPI) Number Confirmation Letter/Email**
- **Current Photo**
- **Current PPD Test Results**
- **Current Immunization Listing**

In order to ensure that your application is processed as quickly as possible, please note the following:

- The application must be completed, signed and dated. Please do not leave any areas or questions blank. If the question does not apply, please indicate by marking "N/A".

- Please ensure that legible copies of the items listed above are included with your application packet. These items are important elements of our verification process. If you are not able to provide a requested document, please provide a comment or explanation as to why, and if/when you will be able to obtain and forward.

Once submitted, our Risk Management Department will process your application as quickly as possible. Should you have any questions about your application, or about locums assignments with MDA, please don't hesitate to contact your Staffing Consultant.

Thank you for allowing us the opportunity to work with you!

NAME: ______________________________

INDEPENDENT CONTRACTOR APPLICATION - ALLIED HEALTH PROVIDER

GENERAL INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME

DEGREE	GENDER	DATE OF BIRTH	SSN	DRIVER'S LICENSE STATE / NUMBER
	☐ MALE ☐ FEMALE	/ /	- -	**STATE #**

SPECIALTY	OTHER NAMES USED	MAIDEN

HOME ADDRESS	ADDRESS LINE 2	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	PAGER	E-MAIL

MAILING ADDRESS, IF DIFFERENT FROM ABOVE	ADDRESS LINE 2	CITY	STATE	ZIP CODE

NAME OF EMPLOYER OR GROUP

CURRENT PRACTICE TYPE ☐ RESIDENT / FELLOW ☐ PRIVATE / SOLO ☐ GROUP OR PARTNERSHIP ☐ RETIRED
☐ HOSPITAL / HMO EMPLOYEE ☐ ACADEMICS ☐ MILITARY / GOVERNMENT ☐ OTHER:

OFFICE ADDRESS	ADDRESS LINE 2	CITY	STATE	ZIP CODE

OFFICE PHONE	OFFICE FAX	U.S. CITIZEN? ☐ YES ☐ NO If not US Citizen, are you authorized work in the US? ☐ YES ☐ NO

NAME OF SUPERVISING PHYSICIAN (IF APPLICABLE)	IF NOT US CITIZEN, PLEASE PROVIDE VISA STATUS	BIRTH PLACE (CITY, ST, COUNTRY)	LANGUAGES SPOKEN FLUENTLY

EMERGENCY CONTACT	RELATIONSHIP	PHONE	CELL PHONE

DO YOU WISH TO CONTRACT WITH MEDICAL DOCTOR ASSOCIATES AS A CORPORATE ENTITY? ☐ YES ☐ NO IF YES, NAME OF ENTITY?	FEDERAL TAX ID #

CERTIFICATIONS

PLEASE CHECK ALL EXAMS AND CERTIFICATIONS THAT MAY APPLY:

EXPIRATION DATE	EXPIRATION DATE	EXPIRATION DATE	EXPIRATION DATE
☐ ACLS / /	☐ BLS / /	☐ ATLS / /	☐ PALS / /

BOARD CERTIFICATION

SPECIALTY	CERTIFYING BOARD	DATE CERTIFIED	RECERTIFICATION DATE	CERTIFICATION #
		/ /	/ /	

EXPIRATION DATE	ELIGIBLE / EXAM DATE	NOT ELIGIBLE / EXPLANATION	# OF ATTEMPTS
/ /	☐ / /	☐ /	

MILITARY SERVICE

BRANCH OF SERVICE	RANK AT DISCHARGE	DATES OF SERVICE: FROM / / TO / /
		TYPE OF DISCHARGE: SERVICE #:

LICENSES AND IDENTIFICATION NUMBERS

STATE	LICENSE #	STATUS: (ACTIVE OR INACTIVE)	CONTROLLED SUBSTANCE #, IF APPLICABLE	STATE	LICENSE #	STATUS: (ACTIVE OR INACTIVE)	CONTROLLED SUBSTANCE #, IF APPLICABLE

DEA #	EXP DATE / /	NATIONAL PROVIDER ID (NPI)

 NAME: ______________________

EDUCATION

UNDERGRADUATE TRAINING / INSTITUTION				DEGREE ATTAINED
ADDRESS		ADDRESS LINE 2		PROGRAM COMPLETED? ☐ YES ☐ NO
CITY	STATE	ZIP CODE	FROM / /	TO / /

GRADUATE EDUCATION

1: TRAINING PROGRAM

INSTITUTION / FACILITY NAME			CHAIRMAN		TYPE OF PROGRAM / SPECIALTY
ADDRESS			ADDRESS LINE 2		Program Completed? ☐ YES ☐ NO
CITY	STATE	ZIP CODE	FROM / /	TO / /	In good standing with the Program? ☐ YES ☐ NO

2: ADDITIONAL GRADUATE TRAINING

INSTITUTION / FACILITY NAME			CHAIRMAN		TYPE OF PROGRAM / SPECIALTY
ADDRESS			ADDRESS LINE 2		Program Completed? ☐ YES ☐ NO
CITY	STATE	ZIP CODE	FROM / /	TO / /	In good standing with the Program? ☐ YES ☐ NO

PROFESSIONAL REFERENCES

PLEASE LIST FOUR (4) COLLEAGUES WHO HAVE WORKED WITH YOU IN THE PAST TWO (2) YEARS AND CAN ATTEST TO YOUR CLINICAL COMPETENCE. IF POSSIBLE, THESE REFERENCES SHOULD BE WITHIN YOUR SPECIALTY.

NAME	SPECIALTY	INSTITUTION		
PHONE	FAX	E-MAIL		
ADDRESS		CITY	STATE	ZIP CODE
NAME	SPECIALTY	INSTITUTION		
PHONE	FAX	E-MAIL		
ADDRESS		CITY	STATE	ZIP CODE
NAME	SPECIALTY	INSTITUTION		
PHONE	FAX	E-MAIL		
ADDRESS		CITY	STATE	ZIP CODE
NAME	SPECIALTY	INSTITUTION		
PHONE	FAX	E-MAIL		
ADDRESS		CITY	STATE	ZIP CODE

NAME: ____________________

HOSPITAL / FACILITY AFFILIATIONS (PRIVILEGES)

HOSPITAL / FACILITY	STAFF STATUS	FROM / /	TO / /	TO PRESENT ☐
ADDRESS	CITY	STATE	ZIP CODE	
HOSPITAL / FACILITY	STAFF STATUS	FROM / /	TO / /	TO PRESENT ☐
ADDRESS	CITY	STATE	ZIP CODE	
HOSPITAL / FACILITY	STAFF STATUS	FROM / /	TO / /	TO PRESENT ☐
ADDRESS	CITY	STATE	ZIP CODE	
HOSPITAL / FACILITY	STAFF STATUS	FROM / /	TO / /	TO PRESENT ☐
ADDRESS	CITY	STATE	ZIP CODE	

AVAILABILITY

AVAILABLE WEEKS PER YEAR: | HOW MUCH ADVANCE NOTICE DO YOU REQUIRE?

SPECIFIC PERIODS OF AVAILABILITY OR UNAVAILABILITY:

AREAS OF GEOGRAPHIC PREFERENCE:

PREVIOUS LOCUM TENENS EXPERIENCE

PLEASE LIST ALL LOCATIONS WHERE YOU HAVE PROVIDED LOCUM TENENS COVERAGE BEGINNING WITH THE MOST RECENT. PLEASE LIST ON AN ADDITIONAL SHEET, IF NECESSARY.

HOW MANY (TOTAL) HOURS ____, AND / OR HOW MANY (TOTAL) DAYS ____ PER YEAR DO YOU PROVIDE LOCUM TENENS COVERAGE?

INSTITUTION / PRACTICE NAME	CONTACT	CITY	STATE	FROM /	TO /
INSTITUTION / PRACTICE NAME	CONTACT	CITY	STATE	FROM /	TO /
INSTITUTION / PRACTICE NAME	CONTACT	CITY	STATE	FROM /	TO /
INSTITUTION / PRACTICE NAME	CONTACT	CITY	STATE	FROM /	TO /

PROFESSIONAL LIABILITY HISTORY

PLEASE LIST ALL POLICIES, CURRENT OR PREVIOUS FOR THE PAST FIVE (5) YEARS OF PROFESSIONAL LIABILITY COVERAGE. **CHECK ONE.**

☐ YES (coverage in the past 5 years, please complete below) ☐ N/A - Training ☐ NA – No Coverage

1 PRESENT OR PREVIOUS INSURANCE CARRIER :

ADDRESS			CITY	STATE	ZIP CODE
POLICY #	TYPE OF POLICY ☐ OCCURRENCE ☐ CLAIMS MADE	POLICY LIMITS $ / $	RETRO. DATE / /	START DATE / /	EXPIRATION DATE / /

2 PRESENT OR PREVIOUS INSURANCE CARRIER:

ADDRESS			CITY	STATE	ZIP CODE
POLICY #	TYPE OF POLICY ☐ OCCURRENCE ☐ CLAIMS MADE	POLICY LIMITS $ / $	RETRO. DATE / /	START DATE / /	EXPIRATION DATE / /

3 PRESENT OR PREVIOUS INSURANCE CARRIER:

ADDRESS			CITY	STATE	ZIP CODE
POLICY #	TYPE OF POLICY ☐ OCCURRENCE ☐ CLAIMS MADE	POLICY LIMITS $ / $	RETRO. DATE / /	START DATE / /	EXPIRATION DATE / /

NAME: ____________________

MISCELLANEOUS QUESTIONNAIRE

PLEASE EXPLAIN ANY "YES" ANSWERS ON A SEPARATE SHEET

#	Question	Answer
1	HAS YOUR LICENSE TO PRACTICE IN ANY JURISDICTION BEEN LIMITED, SUSPENDED, REVOKED, VOLUNTARILY SURRENDERED, REPRIMANDED, ADMONISHED, INVESTIGATED FOR A COMPLAINT OR PLACED UNDER INVESTIGATION, CORRECTIVE ACTION, CONSENT ORDER OR PROBATION, HAD LIMITS ON LICENSURE ISSUANCE, BEEN SUBJECT TO LETTERS OF CONCERN, NOTIFCATION OF PROPOSED ACTIONS OR ANY OTHER LICENSING BOARD ACTIVITY NOT RELATED TO ISSUANCE OR RENEWAL?	☐ YES ☐ NO
2	HAVE YOU EVER BEEN DENIED A LICENSE BY ANY LICENSING BOARD, OR HAVE YOU WITHDRAWN AN APPLICATION FOR LICENSE FOR ANY REASON?	☐ YES ☐ NO
3	HAVE YOU EVER BEEN DENIED CERTIFICATION BY A SPECIALTY BOARD OR NOT BEEN ALLOWED TO SIT FOR AN EXAM FOR ANY REASON?	☐ YES ☐ NO
4	HAS YOUR NARCOTICS LICENSE EVER BEEN SUSPENDED, REVOKED, LIMITED OR VOLUNTARILY SURRENDERED, PUT ON PROBATION, OR HAS PROBATION EVER BEEN REVOKED?	☐ YES ☐ NO ☐ N/A
5	HAVE YOU EVER BEEN DENIED MEMBERSHIP OR RENEWAL THEREOF, OR BEEN SUBJECT TO DISCIPLINARY ACTION, BY ANY MEDICAL ORGANIZATION OR ENTITY?	☐ YES ☐ NO
6	HAVE YOU EVER FAILED TO SATISFACTORILY COMPLETE ANY PORTION OF ANY TRAINING PROGRAM OR HAS YOUR CONTRACT WITH ANY TRAINING PROGRAM NOT BEEN RENEWED FOR WHAT SHOULD HAVE BEEN A SUBSEQUENT YEAR? (If changed programs in good standing, please answer "NO" and provide an explanation for change in programs)	☐ YES ☐ NO
7	ARE YOU NOW, OR HAVE YOU EVER BEEN, UNDER SANCTION OR INVESTIGATION WITH REGARD TO MEDICARE AND / OR MEDICAID?	☐ YES ☐ NO
8	HAVE YOUR PRIVILEGES AT ANY HOSPITAL BEEN DENIED, SUSPENDED, DIMINISHED, REVOKED, WITHDRAWN, OR PLACED UNDER ANY OTHER DISCIPLINARY ACTIONS OR PEER REVIEW, HAVE YOU BEEN NOTIFIED OF ANY PROPROSED ACTIONS, RESTRICTIONS OR SUSPENSION OR HAVE THEY NOT BEEN RENEWED FOR ANY REASON OTHER THAN YOUR OWN VOLUNTARY DECISION NOT TO PRACTICE THERE ANY LONGER?	☐ YES ☐ NO ☐ N/A
9	HAVE YOU EVER BEEN CONVICTED OF A FELONY?	☐ YES ☐ NO
10	HAVE YOU EVER BEEN ASKED TO LEAVE A LOCUM TENENS/PER DIEM/TRAVEL/TEMPORARY WORK ASSIGNMENT PRIOR TO YOUR CONTRACTED WORK END DATE?	☐ YES ☐ NO

PROFESSIONAL LIABILITY QUESTIONNAIRE

#	Question	Answer
1	HAVE YOU **EVER** BEEN DENIED PROFESSIONAL LIABILITY COVERAGE? *IF YES, PLEASE EXPLAIN:	☐ YES* ☐ NO
2	HAS THERE BEEN ANY CHANGE IN YOUR PRACTICE / SPECIALTY IN THE LAST FIVE (5) YEARS? **IF YES, PLEASE EXPLAIN:	☐ YES** ☐ NO
3	HAVE JUDGMENTS, SETTLEMENTS, OR CLAIMS **EVER** BEEN MADE AGAINST YOU IN ANY PROFESSIONAL LIABILITY CASES, OR ARE THERE ANY PENDING AGAINST YOU OR ANY GROUP OR OTHER PROFESSIONAL ENTITY OF WHICH YOU ARE A MEMBER? ***IF YES, PLEASE INDICATE THE NUMBER OF PREVIOUS AND / OR PENDING CLAIMS______. YEARS INCIDENTS OCCURRED: 1______, 2______, 3______, 4______, 5______ PLEASE PROVIDE A DETAILED NARRATIVE OF EACH CLAIM ON THE ATTACHED CLAIM / SUIT INFORMATION FORM, PAGE 9.	☐ YES*** ☐ NO

HEALTH STATUS QUESTIONS

THE FOLLOWING QUESTIONS RELATE TO YOUR HEALTH STATUS AND AFFIRMATIVE ANSWERS ARE NOT A BASIS FOR AUTOMATIC DISQUALIFICATION. THEIR PURPOSE IS TO ASSIST US IN EVALUATING APPROPRIATE PLACEMENTS, TO FACILITATE HIGH QUALITY MEDICAL CARE, AND TO ASSURE THAT ANY NECESSARY PRECAUTIONS ARE IN PLACE. (PLEASE ATTACH ADDITIONAL SHEETS, IF NECESSARY)

#	Question	Answer
1	DO YOU HAVE ANY ALCOHOL OR SUBSTANCE ABUSE PROBLEMS? *IF YES, PLEASE EXPLAIN:	☐ YES* ☐ NO
2	ARE YOU ABLE TO PERFORM, WITH OR WITHOUT ACCOMMODATION, ALL THE ESSENTIAL FUNCTIONS OF THE LOCUM TENENS ASSIGNMENT/AGREEMENT? **IF NO, PLEASE EXPLAIN:	☐ YES ☐ NO**
3	HAVE YOU EVER TESTED POSITIVE FOR TUBERCULOSIS OR HAD A POSITIVE TB SKIN TEST? ***IF YES, YOU MAY BE REQUIRED TO PROVIDE A REPORT OF A CURRENT NEGATIVE CHEST X-RAY PERFORMED AFTER PPD AND LESS THAN ONE YEAR OLD	☐ YES*** ☐ NO
4	HAVE YOU BEEN VACCINATED FOR HEPATITIS B?	☐ YES ☐ NO

ELECTRONIC HEALTH RECORDS (EHR) / ELECTRONIC MEDICAL RECORDS (EMR)

Question	Answer
DO YOU HAVE EXPERIENCE WITH EHR/EMR?	☐ YES ☐ NO

NAME: ______________________

RELEASE & AUTHORIZATION

By signing below, I certify that all information submitted in this application is true and complete. All information is considered material and important. Should Medical Doctor Associates agree to be bound under the terms of this application to provide liability coverage, it is understood this policy is void if it is found that there was any attempt to mislead, defraud or lie about any information contained in this application.

I understand that Medical Doctor Associates may introduce me to various facilities in order to provide medical services through Medical Doctor Associates. I agree to work in such referred facilities only through Medical Doctor Associates for the period described in Medical Doctor Associates' contract except upon payment of a reasonable recruitment fee and as otherwise provided in Medical Doctor Associates contract.

I authorize and release to Medical Doctor Associates and its agents, including CREDENT Verification & Licensing Services, any and all specific Military Service records from any and all branches of the Military and its cognate organizations (including but not limited to: Manpower Offices, Personnel Support Detachments and National Personnel Records Centers and their representatives) and all such data, documents and information whether or not it is otherwise privileged or confidential relating to my education, training, performance, personal character, ethics, rank, privilege, and current status.

I authorize Medical Doctor Associates and its agents to consult with any persons, entities, institutions and/or medical licensing boards, including, but not limited to, the Federation of State Medical Boards, who can provide information or documents, privileged or confidential, relating to my professional competence, ethics, personal character and professional liability history; to provide information, both written and oral, regarding the status of any license which I have possessed; to obtain licensure or hospital privileges for me and to obtain any information described above during that process. I release from liability any and all individuals or entities providing such information, in good faith and without malice, and specifically consent to the release of such information. I also release Medical Doctor Associates from any liability arising out of any request for information, in accordance with this application, that it makes, or use of information it receives, from third parties regarding my professional competence, ethics, character, and professional liability history.

A photocopy of this document shall be acceptable proof to anyone receiving it of my full authorization.

NAME (printed)	
SIGNATURE	DATE

145 Technology Parkway NW
Norcross, GA 30092
1-800-780-3500
Fax: 770-246-0882

MEDPRO PROFESSIONAL LIABILITY APPLICATION

A. WHAT IS YOUR PRESENT SPECIALTY? ______________ SUB-SPECIALTY? ______________

What **percentage of your practice** is devoted to your specialty? ______________ SUB-SPECIALTY? ______________

B. PLEASE CHECK ANY OF THE FOLLOWING PROCEDURES YOU WILL PERFORM:

- ☐ ABORTIONS: Elective ______% OF PRACTICE
- ☐ ABORTIONS: Therapeutic ______% OF PRACTICE
- ☐ ACUPUNCTURE – GENERAL ANESTHETIC
- ☐ ACUPUNCTURE – THERAPEUTIC/LOCAL ANESTHETIC
- ☐ ABDOMINOPLASTY (TUMMY TUCK)
- ☐ ANGIOGRAPHY
- ☐ ANGIOPLASTY
- ☐ ARTHROSCOPY
- ☐ ARTERIOGRAPHY
- ☐ ASSISTING IN MAJOR SURGERY – OWN PATIENTS ONLY
- ☐ ASSISTING IN MAJOR SURGERY – OWN & OTHER THAN OWN PATIENTS
- ☐ BARIATRIC SURGERY – LAPROSCOPIC
- ☐ BARIATRIC SURGERY – NON-LAPROSCOPIC
- ☐ BIOPSY (ENDOSCOPIC)
- ☐ BLEPHAROPIGMENTATION ______% OF PRACTICE
- ☐ BLEPHAROPLASTY - COSMETIC ______% OF PRACTICE
- ☐ BLEPHAROPLASTY - RECONSTRUCTIVE ______% OF PRACTICE
- ☐ BOTOX ______% OF PRACTICE
- ☐ BRACHIOPLASTY
- ☐ BREAST IMPLANTS - COSMETIC ______% OF PRACTICE
- ☐ BREAST IMPLANTS - RECONSTRUCTIVE ______% OF PRACTICE
- ☐ BREAST REDUCTION – COSMETIC
- ☐ BRONCHOSCOPY
- ☐ BRONO-ESOPHAGOLOGY
- ☐ BUTTOCK IMPLANTS
- ☐ CALF IMPLANTS
- ☐ CATARACT SURGERY
- ☐ CATHETERIZATION LEFT HEART
- ☐ CATHETERIZATION RIGHT HEART (OTHER THAN CVP LINES)
- ☐ CATHETERIZATION - SWAN-GANZ
- ☐ CHEEK/CHIN/LIP IMPLANTS
- ☐ CHELATION THERAPY
- ☐ CHMICAL PEELS – SUPERFICIAL
- ☐ CHEMICAL PEELS – MEDIUM
- ☐ CHEMICAL PEELS – DEEP ______% OF PRACTICE
- ☐ CLEFT LIP SURGERY – RECONSTRUCTIVE
- ☐ CLEFT PALATE SURGERY – RECONSTRUCTIVE
- ☐ COLONOSCOPY
- ☐ CRYOSURGERY (CERVICAL)
- ☐ CRYOSURGERY (OTHER THAN EXTERNAL LESIONS)
- ☐ D & C
- ☐ ELECTROMAGNETIC THERAPY
- ☐ DIAGNOSTIC EMBOLIZATION
- ☐ ERCP – UPPER GI
- ☐ FACE LIFTS
- ☐ FACE LIFTS MINI (DONE W/ LASER) ______% OF PRACTICE
- ☐ PHENOL FACIAL PEELS
- ☐ GASTROINTESTINAL ENDOSCOPY
- ☐ GYNECOLOGY – MAJOR SURGERY
- ☐ HAIR TRANSPLANTS – FOLLICULAR UNIT TRANSPLANTATION
- ☐ HAIR TRANSPLANTS – OTHER
- ☐ HVLA ON THE CERVICAL SPINE ON PATIENTS YOUNGER THAN 18 YRS OF AGE
- ☐ KYPHOPLASTY
- ☐ LAPAROSCOPIC CHOLECYSTECTOMY
- ☐ LAPAROSCOPY
- ☐ LASER SURGERY
- ☐ LASER THERAPY (NON-ENDOSCOPIC)
- ☐ LIPOINJECTION ______% OF PRACTICE
- ☐ LIPOSUCTION
  - ☐ OTHER THAN TUMESCENT TECHNIQUE
  - ☐ TUMESCENT TECHNIQUE ONLY ______% OF PRACTICE
- ☐ LITHOTRIPSY
- ☐ LYMPHANGIOGRAPHY
- ☐ MAMMOGRAMS
- ☐ MYELOGRAPHY
- ☐ NEEDLE BIOPSY
- ☐ NERVEBLOCKS
  - ☐ LUMBAR EPIDURAL STEROID
  - ☐ PARASPINAL
  - ☐ SCIATIC
  - ☐ FACET
  - ☐ PARAVERTEBRAL
  - ☐ PERIPHERAL
  - ☐ MYOFASCIAL
  - ☐ OCCIPITAL
  - ☐ TRIGGERPOINT INJECTION
  - ☐ INTRATHECAL PUMPS
  - ☐ SPINAL CORD STIMULATORS
- ☐ OXIDATION THERAPY
- ☐ PACEMAKERS - EPICARDIAL
- ☐ PACEMAKERS - ENDOCARIAL
- ☐ PACEMAKERS - TEMPORARY
- ☐ PERITONEOSCOPY
- ☐ PHLEBOGRAPHY
- ☐ PNUEMOENCEPHALOGRAPHY
- ☐ POLYPECTOMY
- ☐ PRENATAL/GYNECOLOGICAL PRACTICE
  - ☐ SEE PATIENTS DURING THE FIRST & SECOND TRIMESTER
  - ☐ SEE PATIENTS TO TERM BUT DO NOT PERFORM DELIVERY
  - ☐ SEE PATIENTS TO TERM AND PERFORM DELIVERY
  - ☐ NORMAL OBSTETRICAL DELIVERIES - TOTAL PER YEAR? ______
  - ☐ CESAREAN SECTIONS - TOTAL PER YEAR? ______
- ☐ PROLOTHERAPY
- ☐ RADIAL/LASER KERATOTOMY
- ☐ RADIATION/X-RAY THERAPHY
- ☐ RADIOPAQUE DYE – NON IONIC ONLY
- ☐ RADIOPAQUE DYE – OTHER THAN NON IONIC ONLY
- ☐ RECTAL OZONE THERAPY
- ☐ RHINOPLASTY ______% OF PRACTICE
- ☐ SHOCK THERAPY
- ☐ SIGMOIDOSCOPY
  - ☐ LESS THAN 60 CM
  - ☐ GREATER THAN 60 CM
- ☐ SILICONE INJECTIONS ______% OF PRACTICE
- ☐ SKIN FLAP/GRAFTS
  - COSMETIC ______% OF PRACTICE
  - RECONSTRUCTION ______% OF PRACTICE
- ☐ THIGH LIFT
- ☐ TUBAL LIGATIONS
- ☐ VASECTOMIES – OWN PATINETS ONLY
- ☐ VASECTOMIES – OWN & OTHER THAN OWN PATINETS
- ☐ VERTEBORPLASTY
- ☐ WEIGHT CONTROL MEDICATION ______% OF PRACTICE
- ☐ GENERAL/SPINAL/CAUDAL ANESTHESIA
- ☐ OTHER m=MEDICAL TECHNIQUES (DO NOT RESTATE SPECIALTY)
  - LIST PROCEDURES ______
  - LIST PROCEDURES ______

C. INDICATE THE PERCENTAGE OF YOUR SURGICAL PRACTICE DEVOTED TO THE FOLLOWING SURGICAL ACTIVITIES:

______% PLASTIC (RECONSTRUCTION ONLY)
______% PLASTIC (COSMETIC ENHANCEMENT ONLY)
______% OTORHINOLARYNGOLOGY
______% NEUROSURGERY
______% THORACIC
______% CARDIAC
______% VASCULAR
______% OBSTETRICS
______% ORTHOPEDIC (INCLUDING BACK)
______% ORTHOPEDIC (NOT INCLUDING BACK)
______% OPHTHALMOLOGY
______% GYNECOLOGY
______%OTHER (DESCRIBE) ______
______% HAND
______% UROLOGY
______% TRAUMATIC

NAME: ______________

D. IN THE LAST TEN (10) YEARS,

1. Have you discontinued major surgical procedures? ☐ Yes ☐ No ☐ NA
If **Yes**, list procedures **and date** discontinued _____

E. WEIGHT CONTROL SURGERY: IN THE PAST TEN (10) YEARS,

2. Have you performed weight control surgery or prescribed weight control medication? ☐ Yes ☐ No ☐ NA

3. If **yes**, what percentage of your practice (% of patient care) **was** devoted to prescribing anorectic drugs?
☐ <1% ☐ 1%-10% ☐ 11%-50% ☐ >50%
4. If **yes**, what percentage of your practice (% of patient care) **was** devoted to performing weight control surgery?
☐ <1% ☐ 1%-10% ☐ 11%-50% ☐ >50%
5. Do you have ownership interests in a weight control clinic? ☐ Yes ☐ No ☐ NA
6. If **yes**, what is the name of the weight control clinic with which you are affiliated: _____

A. PLEASE FULLY EXPLAIN ANY "YES" ANSWER:

1. Do you treat or review treatment of Federal prison inmates? ☐ Yes ☐ No
2. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, medical license or Medicaid/Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? ☐ Yes ☐ No
If yes, please indicate the date(s): _____
3. Have you had any professional liability insurance refused, canceled or non-renewed? ☐ Yes ☐ No
4. Have you incurred or become aware of having a condition that impairs your ability to practice your medical specialty? (e.g. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction of alcohol, narcotics or other controlled substances, etc.) ☐ Yes ☐ No

If **Yes**, state condition, date(s) and identify your treating physician in the space provided below. In the event of any such impairment, **a statement from your physician attesting to your fitness to practice your specialty must accompany this application.** Further statements may be requested as necessary by the Company to complete the underwriting of your application.

Type	Duration	Treating Physician (Name & Address)

STATE STATUTORY REQUIREMENT

NOTE: ***All applicants must read and initial the following:***
Any person who knowingly files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and also punishable by criminal and/or civil penalties in certain jurisdictions.

Initial Here

PLEASE READ AND SIGN

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician or dentist, firm, or professional association.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT. BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED TO ME OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I further understand and agree that I have no right to demand or expect coverage until the Company has received my completed application.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS **I WILL HAVE NO COVERAGE FOR ANY CLAIM** UNDER ANY POLICY OF INSURANCE FOR WHICH I AM APPLYING.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Date Signed:______________________________ Signature:____

Printed Name:

LOSS INFORMATION (IMPORTANT! COMPLETE FULLY)

PLEASE COMPLETE THE **LOSS INFORMATION SUPPLEMENT** FOR EACH WRITTEN REQUEST, INCIDENT, CLAIM OR SUIT (A, B OR C) BELOW.

REPORT PROFESSIONAL LIABILITY AND MALPRACTICE RELATED MATTERS.

FOR QUESTIONS B AND C BELOW, REPORT ALL MATTERS THAT MIGHT REASONABLY LEAD TO A CLAIM OR SUIT BEING BROUGHT AGAINST YOU EVEN IF YOU BELIEVE
THE CLAIM OR SUIT WOULD BE WITHOUT MERIT.

A. ARE YOU NOW, OR HAVE YOU EVER BEEN INVOLVED, IN A CLAIM OR SUIT ARISING OUT OF THE RENDERING OR FAILURE TO RENDER PROFESSIONAL SERVICES? ☐ YES IF "YES", HOW MANY? ________________ ☐ NO

B. ARE YOU AWARE OF ANY COMPLICATION, INCIDENT OR ADVERSE OUTCOME RESULTING IN INJURY OR DEATH THAT MIGHT REASONABLY RESULT IN A CLAIM OR SUIT AGAINST YOU? THIS INCLUDES, BUT IS NOT LIMITED TO, THE FOLLOWING:-

-AMPUTATION - LOSS OF MAJOR ORGAN FUNCTION - PERMANENT NEUROLOGICAL INJURY
- DEATH - LOSS OF VISION ☐ YES IF "YES", HOW MANY? ________________ ☐ NO

C. IN THE LAST 12 MONTHS, HAVE YOU OR ANYONE FROM YOUR PRACTICE RECEIVED A WRITTEN REQUEST FROM AN ATTORNEY FOR TREATMENT RECORDS CONCERNING ANY OF YOUR CURRENT OR FORMER PATIENTS THAT MIGHT REASONABLY RESULT IN A CLAIM OR SUIT AGAINST YOU?
☐ YES IF "YES", HOW MANY? ________________ ☐ NO

IF REPORTED TO YOUR INSURER, PLEASE PROVIDE A COPY OF THE REPORT(S).

CLAIM / SUIT INFORMATION FORM (A Page 9 is required for each claim/suit reported)

If making additional copies, please enter applicants name here: _____

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED BY THE UNDERWRITING DEPARTMENT.

1. Claimant Information – Age: _____ Gender: ☐ Male ☐ Female
2. Date of treatment and /or surgery, which led to the allegations against you: _____
3. Date claim/incident notice received (MM/YY): /
4. Date claim reported to prior insurer (MM/YY): /
5. Name of other doctor(s), hospital(s) or health care provider(s), if any, involved in the claim or suit: _____
6. Disposition or current status of claim or suit: ☐Open ☐Closed Date of Closing/Settlement or award (MM/YY): /
7. Indicate case value established by carrier, if known (in $): _____
8. Defending Insurance carrier name: _____
9. Claim file number, if known: _____
10. Was this matter closed with your consent? ☐ Yes ☐ No
    Was a claim made or a suit filed? ☐ Yes ☐ No
    Was payment made? ☐ Yes ☐ No
    If no, was claim or suit withdrawn? ☐ Yes ☐ No
    If Yes, indicate total amount of settlement or award (in $): _____
    Amount paid on your behalf (in $): _____
11. Nature of allegations in the claim or suit:
    Condition treated: _____
    Treatment provided: _____
    Alleged negligence: _____
    Alleged injury: _____

12. Please provide a narrative description of the medical facts: (must include, but not limited to the type of treatment and / or surgery; your involvement)

_____

 NAME: ____________________

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ ____________

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

Employer identification number
☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

MedicalDoctor ASSOCIATES

TRAVELER PROFILE

PASSENGER INFORMATION

PLEASE ENTER ALL IDENTIFYING INFORMATION AS IT APPEARS ON YOUR DRIVERS LICENSE AND/OR PASSPORT.

LAST NAME	FIRST NAME	MIDDLE NAME

GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH / /

HOME ADDRESS	CITY	STATE	ZIP

WORK PHONE	HOME PHONE	CELL PHONE

COPY ITINERARY TO	HOME AIRPORT

AIR TRAVEL PREFERENCES

SEATING PREFERENCE (CHECK ONE)	OTHER SEATING PREFERENCES	MEAL REQUEST
☐ Aisle ☐ Window		

SPECIAL REQUIREMENTS

FREQUENT FLYER

PROGRAM	NUMBER

HOTEL STAY PREFERENCES

ROOM TYPE	OTHER ROOM PREFERENCES

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT	PHONE	CELL PHONE
/		

PLEASE FORWARD TO THE TRAVEL DEPARTMENT.

NAME: ______________________