FAITH, HOPE AND LOVE

HOPE STREET FREE CLINIC
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Licensed independent practitioners (LIP) Application form:
Name: _____

1. Has your insurance carrier ever refused to renew your policy, placed limitations on your scope of coverage, excluded any specific procedures or area of practice from your coverage or terminated coverage? YES / NO
2. Have you ever been denied professional liability insurance coverage or rated in a higher than average risk class for your specialty? YES / NO
3. Have you EVER had any malpractice actions that are pending, settled, arbitrated, mediated, or litigated? YES / NO
4. Have you ever withdrawn an application for appointment, reappointment or clinical privileges or failed to seek reappointment or renewal of medical staff membership or privileges for any reason, or resigned from the Medical Staff before a decision was made by a heath care facility's governing board? YES / NO
5. Has your appointment, staff category, scope of clinical privileges, employment or the nature of your medical practice ever changed at any hospital, other healthcare institution or training program? YES / NO
6. Have your clinical privileges or Medical Staff membership at any hospital, other healthcare institution or training program ever been voluntarily or involuntarily limited, reduced, excluded, denied, suspended, revoked, restricted, surrendered, relinquished, denied renewal or subject to probationary or to other disciplinary conditions or have investigations or proceedings toward any of those ends been instituted or recommended by any hospital, other healthcare entity, training program, medical staff committee, or governing board? YES / NO
7. Have any investigations or disciplinary actions ever been initiated or are there pending challenges against you by any state licensure board? YES / NO
8. Has your license to practice ever been involuntarily or voluntarily denied, limited, suspended, revoked, relinquished or surrendered or have you ever been subject to any disciplinary actions, by a state licensing board? YES / NO
9. Have you ever voluntarily or involuntarily obtained or been required to obtain additional education or training, proctoring, supervision, or consultation as a result of peer review of quality assurance/improvement or utilization review activities by any type of healthcare entity? YES / NO
10. Have you ever been disciplined, excluded from, suspended, reprimanded, sanctioned, censured, investigated, disqualified, declared an ineligible person or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to any other private, federal or state governmental health care plans or programs, or are there any such actions pending?
YES / NO
11. Have you ever been convicted of, pled guilty to, pled nolo contendere to, received deferred adjudication, or formally charged with a felony or misdemeanor (including DUI) other than minor traffic violations? YES / NO
12. Have you ever been named a defendant in any criminal proceedings? YES/NO
13. Have you ever been charged or convicted of any crime related to your clinical practice including Medicare or Medicaid related crimes or have you ever been subject to civil money penalties under the Medicare or Medicaid program? YES/NO

14. Have your Federal DEA and/or Controlled Substances Certificate(s), registrations or authorization(s) in any state, ever been voluntarily or involuntarily denied, limited, suspended, revoked, restricted, denied renewal, or relinquished, or are any such challenges currently pending? If so, which registration number and state? YES / NO
15. Has your membership in any medical/professional society or association ever been voluntarily or involuntarily challenged, denied, limited, suspended, revoked or relinquished,
or, are there any actions currently pending that would affect your membership in any medical/professional society? YES / NO
16. Do you have any condition that impairs your current ability to provide patient care or fulfill the essential functions of medical staff membership or participation in any healthcare? YES / NO

Any Additional information to disclose: _____
_____
_____
_____

Name: _____
Signature: _____
Date: _____