Delta Dental of New Mexico
Provider Credentialing Profile

Instructions

Read all instructions carefully and fill in all fields prior to submitting your application.

Please enclose a copy of the following with this completed Provider Credentialing Profile:

1. All applicable signed Delta Dental Participating Provider Agreements (for initial credentialing only)
2. Current state(s) license(s) and specialty certification
3. Current professional liability (malpractice) certificate declaration page (each Participating Provider in a group practice must include the requested information)
4. Copy of sedation license, if applicable
5. DEA and CDS certificates, if applicable
6. CPR or Basic Life Support certificate
7. IRS Form W-9

Section 1 – Provider's Personal Information and Professional IDs

Provider's Personal Information

Do not use nicknames or initials, unless they are part of your legal name.

Name (Last, First, Middle Initial)		Suffix (e.g., Jr., III)	Gender: ☐ M ☐ F
Social Security Number	Date of Birth (MM/DD/YYYY)		
City of Birth	State of Birth	Country of Birth	
List All Non-English Languages You Speak			

Provider's Personal Contact Information

Provider's Home Address (including City, State, and ZIP Code)	
Provider's Home Telephone	Provider's Personal Email Address

Professional IDs

- Include all state licenses, DEA registration, and state Controlled Dangerous Substance (CDS) certification numbers
- Provide all current and previous licenses/certifications
- A non-licensed professional must submit a letter attesting that he or she will not prescribe medication in the state of New Mexico

Federal DEA Number	DEA Issue Date (MM/DD/YYYY)
DEA State of Registration	DEA Expiration Date (MM/DD/YYYY)

CDS Certificate Number		CDS Issue Date (MM/DD/YYYY)
CDS State of Registration		CDS Expiration Date (MM/DD/YYYY)
State License Number - 1	License Issuing State	License Issue Date (MM/DD/YYYY)
Are you currently practicing in this state? ☐ Y ☐ N		License Expiration Date (MM/DD/YYYY)
State License Number - 2	License Issuing State	License Issue Date (MM/DD/YYYY)
Are you currently practicing in this state? ☐ Y ☐ N		License Expiration Date (MM/DD/YYYY)

Other ID Numbers

Are you a participating Medicare provider? ☐ Y ☐ N	Medicare Number
Are you a participating Medicaid provider? ☐ Y ☐ N	Medicaid Number
National Provider Identification (NPI) Number Type 1	

Section 2 – Education and Training

Graduate or Professional School(s)

Name of School - 1	
Start Date (MM/DD/YYYY)	End Date/Graduation Date (MM/DD/YYYY)
Did you complete your graduate education at this school? ☐ Y ☐ N	Degree Awarded
Name of School - 2	
Start Date (MM/DD/YYYY)	End Date/Graduation Date (MM/DD/YYYY)
Did you complete your graduate education at this school? ☐ Y ☐ N	Degree Awarded

Training

If you attended a training program, please describe it below.

Institution/Hospital Name		
Street Address (including City, State, and ZIP Code)		
Country	Telephone	Fax
Did you complete your training at this school? ☐ Y ☐ N		

Section 3 – Professional Specialty

Primary Specialty

Specialty	Board Certified? ☐ Y ☐ N

Certifications

Do you hold the following certifications? If yes, provide expiration dates.

Basic Life Support ☐ Y ☐ N	Expiration Date (MM/DD/YYYY)
CPR ☐ Y ☐ N	Expiration Date (MM/DD/YYYY)
Pediatric Advanced Life Support ☐ Y ☐ N	Expiration Date (MM/DD/YYYY)

Section 4 – Practice Location Information

A Provider will only be listed in our Provider directories at his or her Primary Practice Locations. Providers will remain credentialed at all locations to allow for claims processing.

If you have additional practice locations, use the Practice Location Information Supplemental Form on pages 17-18.

Primary Practice Location

Business Name	
If not currently practicing here, what is your expected start date? Note: We cannot process applications submitted more than 30 days before the start date.	Expected Start Date (MM/DD/YYYY)
Is this a Primary Practice Location? ☐ Y ☐ N **Note:** A Primary Practice Location is defined as a location where you are scheduled to see Delta Dental patients at least one day per month. You can have multiple Primary Practice Locations.	
Street Address (including City, State, and ZIP Code)	
Telephone	Fax

Office Email Address	Web Site
Billing Tax ID	National Provider Identification (NPI) Number Type 2

Office Manager or Business Office Staff Contact

Name (Last, First, Middle Initial)	
Street Address (including City, State, and ZIP Code)	
Telephone	Fax
Email Address	

Payment Remittance Address

If you want Delta Dental to send payments and mailings to an address different from the Primary Practice Location, please specify the different address here.

Payment Remittance Address (including City, State, and ZIP Code)

Office Hours

Use HH:MM format and round to the nearest half-hour. Include AM or PM, e.g., 9:30AM or 1:00PM.

Day	Start Time	End Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

24/7 Phone Coverage?	If yes:
☐ Y ☐ N	☐ Answering Service ☐ Voice mail with instructions to call answering service

Open Practice Status

Accept new patients into this practice?	☐ Y ☐ N
Accept existing patients with change of payor?	☐ Y ☐ N
Accept new patients with physician referral?	☐ Y ☐ N
Accept all new patients?	☐ Y ☐ N
Accept new Medicare patients?	☐ Y ☐ N
Accept new Medicaid patients?	☐ Y ☐ N

Age Limitations

Minimum Age Accepted	Maximum Age Accepted

Mid-Level Practitioners

Practitioner Name (Last, First, Middle Initial)		
Practitioner Type (e.g., PA, CNP, NP)	Practitioner License/Certificate Number	Practitioner State

Languages

List All Non-English Languages Spoken by Office Personnel

Interpreters available? ☐ Y ☐ N

Accessibilities

Does this office meet ADA accessibility requirements?	☐ Y ☐ N
Does this site offer handicapped access for the following?	
Building	☐ Y ☐ N
Parking	☐ Y ☐ N

Restroom	☐ **Y** ☐ **N**
Treats Special Needs Adults	☐ **Y** ☐ **N**
Treats Special Needs Children	☐ **Y** ☐ **N**
Text Telephony (TTY)	☐ **Y** ☐ **N**
American Sign Language	☐ **Y** ☐ **N**
Accessible by Public Transportation?	☐ **Y** ☐ **N**

Office Questions

1. Are all individuals treating patients fully licensed to the scope of their licensure?	☐ **Y** ☐ **N**
2. Does your office practice universal precautions for infection control (compliance with Centers for Disease Control and Prevention (CDC) Guidelines on Infection Control Practices for Dentistry)?	☐ **Y** ☐ **N**
3. Are all permits or filings required by law and regulation current and valid (e.g., radiographic equipment)?	☐ **Y** ☐ **N**
4. Are you and/or your staff trained in CPR?	☐ **Y** ☐ **N**
5. Is your office OSHA compliant?	☐ **Y** ☐ **N**
6. Do your radiographic techniques meet accepted professional standards?	☐ **Y** ☐ **N**
7. Do you take an initial medical/dental history with periodic updates?	☐ **Y** ☐ **N**

Partners/Associates

List all partners/associates at this practice. If you have additional partners/associates at THIS location, use the Partners/Associates Supplemental Form on page 16. Photocopy as necessary.

Partner/Associate's Name – 1 (Last, First, Middle Initial)
Specialty
Partner/Associate's Name – 2 (Last, First, Middle Initial)

Specialty
Partner/Associate's Name – 3 (Last, First, Middle Initial)
Specialty

Section 5 – Hospital Affiliations

Admitting Arrangements

Do you have hospital privileges? ☐ **Y** ☐ **N**

If you do not admit patients, what type of admitting arrangements do you have?

_____

_____

Hospital Privileges

Primary Hospital Name	
Street Address (including City, State, and ZIP Code)	
Telephone	Fax
Department Name	
Department Director's Name (Last, First, Middle Initial)	
Affiliation Start Date (MM/DD/YYYY)	Affiliation End Date (MM/DD/YYYY)
Full, Unrestricted Privileges? ☐ Y ☐ N	Are Privileges Temporary? ☐ Y ☐ N
Admitting Privilege Status (e.g., None, Full Unrestricted, Provisional, Temporary)	
Of your total annual admissions, what percentage is to this hospital? _____ %	

Section 6 – Professional Liability Insurance Carrier

Carrier or Self-Insured Name	Self-Insured? ☐ Y ☐ N
Street Address (including City, State, and ZIP Code)	

Effective Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)
Type of Coverage ☐ Individual ☐ Shared	Do you have unlimited coverage with this insurance carrier? ☐ Y ☐ N
Amount of Coverage per Occurrence (in Dollars)	Amount of Coverage Aggregate (in Dollars)
Policy Includes Tail Coverage? ☐ Y ☐ N	Policy Number

Section 7 – Work History and References

Military Duty

Are you currently on active military duty or military reserve? ☐ **Y** ☐ **N**

Work History

Include a chronological work history for the past 10 years. If you have additional work history, use the Additional Work History Supplemental Form on page 21. Photocopy as needed.

Practice/Employer Name - 1		
Street Address (including City, State, and ZIP Code)		
Telephone	Email Address	
Country	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)
Reason for Departure (if Applicable)		
Practice/Employer Name - 2		
Street Address (including City, State, and ZIP Code)		
Telephone	Email Address	
Country	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)
Reason for Departure (if Applicable)		
Practice/Employer Name - 3		

Street Address (including City, State, and ZIP Code)		
Telephone	Email Address	
Country	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)
Reason for Departure (if Applicable)		

Gaps in Professional/Work History

Please explain any time periods or gaps in training or work history that have occurred since graduation from professional school and are longer than three months in duration.

Gap Start Date (MM/DD/YYYY)	Gap End Date (MM/DD/YYYY)
Explanation for Gap	

Professional References

Provide three professional references to whom you are not related or who are not partners in your practice. You are required to provide exactly three references.

Reference's Name - 1 (Last, First, Middle Initial)	
Street Address (including City, State, and ZIP Code)	
Telephone	Email Address
Reference's Name - 2 (Last, First, Middle Initial)	
Street Address (including City, State, and ZIP Code)	
Telephone	Email Address
Reference's Name - 3 (Last, First, Middle Initial)	
Street Address (including City, State, and ZIP Code)	
Telephone	Email Address

Section 8 – Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Disclosure Questions Supplemental Form on page 19.

Licensure

1. Has your license, registration, or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, or restricted, or have you ever been subject to a fine, reprimand, consent order, probation, or any conditions or limitations by any state or professional licensing, registration, or certification board?	☐ **Y** ☐ **N**
2. Has there been any challenge to your licensure, registration, or certification?	☐ **Y** ☐ **N**

Hospital Privileges and Other Affiliations

3. Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal, or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?	☐ **Y** ☐ **N**
4. Have you voluntarily or involuntarily surrendered, limited your privileges, or not reapplied for privileges while under investigation?	☐ **Y** ☐ **N**
5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?	☐ **Y** ☐ **N**

Education, Training, and Board Certification

6. Were you ever placed on probation, disciplined, formally reprimanded, suspended, or asked to resign during an internship, residency, fellowship, preceptorship, or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended, or asked to resign?	☐ **Y** ☐ **N**
7. Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?	☐ **Y** ☐ **N**
8. Have any of your board certifications or eligibility ever been revoked?	☐ **Y** ☐ **N**
9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?	☐ **Y** ☐ **N**

DEA or State Controlled Substance Registration

10. Have your federal DEA and/or state Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?	☐ **Y** ☐ **N**

Medicare, Medicaid, or Other Governmental Program Participation

11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified, or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?	☐ **Y** ☐ **N**

Other Sanctions or Investigations

12. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal, or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse, or a sexual offense or sexual misconduct?	☐ **Y** ☐ **N**
13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?	☐ **Y** ☐ **N**
14. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?	☐ **Y** ☐ **N**
15. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined, or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?	☐ **Y** ☐ **N**
16. Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?	☐ **Y** ☐ **N**

Professional Liability Insurance Information and Claims History

17. Has your professional liability coverage ever been cancelled, restricted, declined, or not renewed by the carrier based on your individual liability history?	☐ **Y** ☐ **N**
18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?	☐ **Y** ☐ **N**

Malpractice Claims History

19. Have you had any professional liability actions (pending, settled, arbitrated, mediated, or litigated) within the past seven years? If yes, provide information for each case. **Important:** If you answered "Yes" to this question, you must complete the Malpractice Claims Explanation Supplemental Form on page 20 for each malpractice claim.	☐ **Y** ☐ **N**

Criminal/Civil History

Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by Delta Dental of New Mexico based upon all the relevant circumstances, including the nature of the crime.

20. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?	☐ **Y** ☐ **N**

21. In the past seven years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse, or a sexual offense or sexual misconduct?	☐ **Y** ☐ **N**
22. Have you ever been court-martialed for actions related to your duties as a medical professional?	☐ **Y** ☐ **N**

Ability to Perform Job

23. Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)	☐ **Y** ☐ **N**
24. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?	☐ **Y** ☐ **N**
25. Do you have any reason to believe that you would pose a risk to the safety or wellbeing of your patients?	☐ **Y** ☐ **N**
26. Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?	☐ **Y** ☐ **N**
Do you have experience or training in providing dental services to the following? (check all that apply)	
27. Adults with special needs	☐ **Y** ☐ **N**
28. Persons suffering from chronic illness, including HIV or AIDS	☐ **Y** ☐ **N**
29. Persons suffering from mental illness	☐ **Y** ☐ **N**
30. Persons who are hearing impaired	☐ **Y** ☐ **N**
31. Persons who are vision impaired	☐ **Y** ☐ **N**
32. Persons who are homeless	☐ **Y** ☐ **N**

33. Children with special needs	☐ **Y** ☐ **N**

Medicare Part D - Please Check One

☐ I have enrolled as a Medicare provider.

☐ I have opted out of the Medicare program.

☐ I have enrolled as a Medicare ordering/referring provider.

☐ I have taken no action.

Section 9 – Standard Authorization, Attestation, and Release

I understand and agree that, as part of the credentialing application process for participation, membership, and/or clinical privileges (hereinafter, referred to as "Participation") with Delta Dental, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by Delta Dental for determining initial and ongoing eligibility for Participation. Delta Dental and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that Delta Dental has criteria for acceptance, and I may be accepted or rejected. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that Delta Dental will grant me clinical privileges or contract with me as a Provider of services. I understand that my application for Participation with Delta Dental is not an application for employment with Delta Dental and that acceptance of my application by Delta Dental will not result in my employment by Delta Dental.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, Delta Dental, its representatives, employees, and/or designated agent(s); Delta Dental's affiliated entities and their representatives, employees, and/or designated agents; and Delta Dental's designated professional credentials verification personnel (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow Delta Dental and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to Delta Dental and/or its Agent(s) information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, Delta Dental. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation, and Release.

I certify that the information contained herein, including all supporting materials, is true and complete to the best of my knowledge and belief. I understand and agree that my application will be reviewed based upon the information I have provided and other information obtained by Delta Dental of New Mexico in accordance with its credentialing program. I further understand and agree that information which is found to be false, or any misstatement or material omission, will constitute grounds for rejection of my application and could result in the termination of my Delta Dental Participating Provider Agreement. I further agree to notify Delta Dental of New Mexico, in writing, of any change in the information I have provided in this

document regarding my professional liability coverage or any action against my professional license within 30 days of its occurrence.

I authorize the New Mexico Board of Dental Health Care (or other dental licensing agencies in any state in which I have been licensed to practice dentistry), and any health care facility, health maintenance organization, or professional organization with whom I have had employment, practice, association, or privileges, to release information to Delta Dental regarding any pending or final disciplinary or malpractice action.

Release from Liability. I release from all liability and hold harmless Delta Dental, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of Delta Dental, its Agent(s), or other third party in connection with the gathering, release, and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation, and Release. I further agree not to sue Delta Dental, any Agent(s), or any other third party for their acts, defamation, or any other claims based on statements made in good faith and without malice or misconduct of Delta Dental, Agent(s), or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation, and Release, all references to Delta Dental, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and Agents. Delta Dental or any of its affiliates or Agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation, and Release is irrevocable for any period during which I am an applicant for Participation with Delta Dental, a member of Delta Dental's health care staff, or a Participating Provider of Delta Dental. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by Delta Dental in accordance with the applicable bylaws, rules and regulations, and requirements of Delta Dental, or grounds for my termination of Participation at or with Delta Dental. I agree that information obtained in accordance with the provisions of this Authorization, Attestation, and Release is not and will not be a violation of my privacy.

I understand that submission of this application is not a guarantee of its approval and that Delta Dental reserves the right to reject an application for any reason it deems appropriate or necessary.

_____ _____

Signature Name (print)

_____

Date Signed

Supplemental Forms (Fill Out As Needed)

Partners/Associates Supplemental Form

Use this page to report additional partners/associates. If you need to report more partners/associates, photocopy this page as needed and submit as instructed.

Partner/Associate's Name (Last, First, Middle Initial)
Specialty
Partner/Associate's Name (Last, First, Middle Initial)
Specialty
Partner/Associate's Name (Last, First, Middle Initial)
Specialty
Partner/Associate's Name (Last, First, Middle Initial)
Specialty
Partner/Associate's Name (Last, First, Middle Initial)
Specialty
Partner/Associate's Name (Last, First, Middle Initial)
Specialty
Partner/Associate's Name (Last, First, Middle Initial)
Specialty
Partner/Associate's Name (Last, First, Middle Initial)
Specialty

Practice Location Information Supplemental Form

In the box provided, indicate to which practice location this page belongs. For example, if you practice at three locations, the Primary Practice Location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

Location #	Business Name

If not currently practicing here, what is your expected start date? **Note:** We cannot process applications submitted more than 30 days before the start date.	Expected Start Date (MM/DD/YYYY)

Is this a Primary Practice Location? ☐ Y ☐ N

Note: A Primary Practice Location is defined as a location where you are scheduled to see Delta Dental patients at least one day per month. You can have multiple Primary Practice Locations.

Street Address (including City, State, and ZIP Code)	
Telephone	**Fax**
Office Email Address	**Web Site**
Billing Tax ID	**National Provider Identification (NPI) Number Type 2**

Office Manager or Business Office Staff Contact

Name (Last, First, Middle Initial)	
Street Address (including City, State, and ZIP Code)	
Telephone	**Fax**
Email Address	

Office Hours

Use HH:MM format and round to the nearest half-hour. Include AM or PM, e.g., 9:30AM or 1:00PM.

Day	Start Time	End Time
Monday		
Tuesday		
Wednesday		

Thursday		
Friday		
Saturday		
Sunday		

24/7 Phone Coverage? ☐ Y ☐ N	If yes: ☐ Answering Service ☐ Voice mail with instructions to call answering service

Age Limitations

Minimum Age Accepted	Maximum Age Accepted

Disclosure Questions Supplemental Form

Use this form to report any "Yes" response to one or more of the Disclosure Questions in Section 8. If you need additional space to explain a "Yes" response, photocopy this page as needed and submit as instructed.

Question #: _____

Explanation: _____

Question #: _____

Explanation: _____

Question #: _____

Explanation: _____

Malpractice Claims Explanation Supplemental Form

Use this form to report any "Yes" response to Disclosure Question #19. If you need additional space to explain a "Yes" response, photocopy this page as needed and submit as instructed.

Date of Occurrence (MM/DD/YYYY)	Date Claim Was Filed (MM/DD/YYYY)
Status of Claim (Note: If Case Is Pending, Select "Open") ☐ Open ☐ Closed	If Settled, Enter Date Claim Was Settled (MM/DD/YYYY)
Professional Liability Carrier Involved	
Street Address (including City, State, and ZIP Code)	
Telephone	Policy Number
Amount of Award or Settlement (in Dollars)	
Method of Resolution? ☐ Dismissed ☐ Settled ☐ Mediation ☐ Arbitration ☐ Judgment for Defendant(s) ☐ Judgment for Plaintiff(s)	
Description of Allegations	
Were you the Primary Defendant or Co-Defendant? ☐ Primary Defendant ☐ Co-Defendant	Number of Other Co-Defendants (if Any)
Your Involvement in Case (Attending, Consulting, etc.)	
Description of Alleged Injury to the Patient	
Did the Alleged Injury Result In Death? ☐ Y ☐ N	To the best of your knowledge, is the case included in the National Practitioner Data Bank (NPDB)? ☐ Y ☐ N

Additional Work History Supplemental Form

Practice/Employer Name		
Street Address (including City, State, and ZIP Code)		
Telephone	Email Address	
Country	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)
Reason for Departure (if Applicable)		
Practice/Employer Name		
Street Address (including City, State, and ZIP Code)		
Telephone	Email Address	
Country	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)
Reason for Departure (if Applicable)		
Practice/Employer Name		
Street Address (including City, State, and ZIP Code)		
Telephone	Email Address	
Country	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)
Reason for Departure (if Applicable)		

Gaps in Professional/Work History

Please explain any time periods or gaps in training or work history that have occurred since graduation from professional school and are longer than three months in duration.

Gap Start Date (MM/DD/YYYY)	Gap End Date (MM/DD/YYYY)
Explanation for Gap	