Medical Doctor ASSOCIATES

FOR INTERNAL USE ONLY: LT_APP ID:_____

PHYSICIAN:_____

RECRUITER:_____

SPECIALTY:_____

SIGN OFF:_____

We are excited to welcome you to working locum tenens with with Medical Doctor Associates, Your Proven Quality Partner in Medical Staffing. Please complete and return the enclosed application packed 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 older than five years must include month and year, and not contain any gaps in time.)*
- ☐ **Medical School Diploma**
- ☐ **Internship Certificate**
- ☐ **Residency Certificate**
- ☐ **Fellowship Certificate**
- ☐ **Board Certification** *(Certificate or Letter)*
- ☐ **Active and Inactive Medical Licenses** *(Wallet Copy)*
- ☐ **ECFMG Certificate**
- ☐ **IRS W-9 Form**
- ☐ **Federal DEA/State Controlled Dangerous Substances Permits**
- ☐ **Advanced Cardiac Life Supprt (ACLS); Basic Cardiac Life Support (BCLS); Advanced Trauma Life Support (ATLS); Pediatric Advanced Life Support (PALS)** *(Please include copies of all applicable.)*
- ☐ **USMLE**
- ☐ **National Practitioner Identifier (NPI) Number Confirmation/Email**
- ☐ **Current Certificate of Insurance (if not utilizing MDA's coverage)**
- ☐ **Current Photo**

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 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 ask your Staffing Consultant.

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

Name: _____

INITIAL PHYSICIAN APPLICATION

GENERAL INFORMATION

LAST NAME		FIRST NAME		MIDDLE NAME	
DEGREE (MD, DO, ETC.)	GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH	SSN	DRIVERS LICENSE STATE/NUMBER	
SPECIALTY		OTHER NAMES USED		MAIDEN	
HOME ADDRESS		CITY		STATE	ZIP
HOME PHONE		CELL PHONE		EMAIL	
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)		CITY		STATE	ZIP
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		CITY	STATE	ZIP
OFFICE PHONE	OFFICE FAX	US CITIZEN ☐ YES ☐ NO IF NOT A US CITIZEN, ARE YOU AUTHORIZED TO WORK IN THE US? ☐ YES ☐ NO		
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 #	

EXAMS AND CERTIFICATIONS

PLEASE CHECK ALL EXAMS AND CERTIFICATIONS THAT MAY APPLY

☐ ACLS EXPIRATION DATE / /	☐ BLS EXPIRATION DATE / /	☐ ATLS EXPIRATION DATE / /	☐ PALS EXPIRATION DATE / /
☐ FLEX DATE: / / # ATTEMPTS:		USMLE: ☐ STEP 1: DATE: / / # ATTEMPTS:	
☐ NATIONAL BOARDS/NBOME DATE: / / # ATTEMPTS:		☐ STEP 2: DATE: / / # ATTEMPTS:	
☐ ECFMG DATE: / / # ATTEMPTS:		☐ STEP 3 DATE: / / # ATTEMPTS:	

MILITARY SERVICE

BRANCH OF SERVICE	DATES OF SERVICE: FROM / / TO: / /	
RANK AT DISCHARGE	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: _____

ABMS/AOA BOARD CERTIFICATIONS

CERTIFYING BOARD			SPECIALTY	DATE CERTIFIED / /	RECERTIFICATION DATE / /	CERTIFICATION #
EXPIRATION DATE / /	LIFETIME ☐	ELIGIBLE/EXAM DATE / /	NOT ELIGIBLE OR CERTIFIED EXPLANATION			# OF ATTEMPTS
SPECIALTY			CERTIFYING BOARD	DATE CERTIFIED / /	RECERTIFICATION DATE / /	CERTIFICATION #
EXPIRATION DATE / /	LIFETIME ☐	ELIGIBLE/EXAM DATE / /	NOT ELIGIBLE OR CERTIFIED EXPLANATION			# OF ATTEMPTS

MEDICAL EDUCATION

MEDICAL/OSTEOPATHIC SCHOOL				DEGREE ATTAINED
ADDRESS				PROGRAM COMPLETED? ☐ YES ☐ NO
CITY	STATE	ZIP	FROM / /	TO / /

POST GRADUATE EDUCATION

1. INTERNSHIP RESIDENCY FELLOWSHIP OTHER: _____

INSTITUTION/FACILITY NAME			CHAIRMAN		TYPE OF PROGRAM/SPECIALTY
ADDRESS					PROGRAM COMPLETED? ☐ YES ☐ NO
CITY	STATE	ZIP	FROM / /	TO / /	IN GOOD STANDING WITH THE PROGRAM? ☐ YES ☐ NO

2. INTERNSHIP RESIDENCY FELLOWSHIP OTHER: _____

INSTITUTION/FACILITY NAME			CHAIRMAN		TYPE OF PROGRAM/SPECIALTY
ADDRESS					PROGRAM COMPLETED? ☐ YES ☐ NO
CITY	STATE	ZIP	FROM / /	TO / /	IN GOOD STANDING WITH THE PROGRAM? ☐ YES ☐ NO

3. INTERNSHIP RESIDENCY FELLOWSHIP OTHER: _____

INSTITUTION/FACILITY NAME			CHAIRMAN		TYPE OF PROGRAM/SPECIALTY
ADDRESS					PROGRAM COMPLETED? ☐ YES ☐ NO
CITY	STATE	ZIP	FROM / /	TO / /	IN GOOD STANDING WITH THE PROGRAM? ☐ YES ☐ NO

PROFESSIONAL REFERENCES

PLEASE LIST THREE COLLEAGUES WHO HAVE WORKED WITH YOU **IN THE PAST TWO YEARS** AND CAN ATTEST TO YOUR CLINICAL COMPETENCE. IF POSSIBLE THESE REFERENCES SHOULD BE **WITHIN YOUR SPECIALTY**.

NAME	SPECIALTY	INSTITUTION		
PHONE	FAX	EMAIL		
ADDRESS		CITY	STATE	ZIP
NAME	SPECIALTY	INSTITUTION		
PHONE	FAX	EMAIL		
ADDRESS		CITY	STATE	ZIP
NAME	SPECIALTY	INSTITUTION		
PHONE	FAX	EMAIL		
ADDRESS		CITY	STATE	ZIP
NAME	SPECIALTY	INSTITUTION		
PHONE	FAX	EMAIL		
ADDRESS		CITY	STATE	ZIP

Name: _____

HOSPITAL/FACILITY AFFILIATIONS (PRIVILEGES)

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

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 WORKED _____ 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 YEARS OF PROFESSIONAL LIABILITY COVERAGE.

CHECK ONE ☐ YES (COVERAGE IN THE PAST 5 YEARS, PLEASE COMPLETE BELOW) ☐ N/A - TRAINING ☐ N/A - NO COVERAGE

1, PRESENT OR PREVIOUS INSURANCE CARRIER:

ADDRESS			CITY	STATE	ZIP
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
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
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

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 of probation, had limits on licensure issuance, been subject to letters of concern, notification 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 of 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, or have you been notified of any proposed 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

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 on 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 THE HIGH QUALITY OF MEDICAL CARE, AND TO ASSURE THAT ANY NECESSARY PRECAUTIONS ARE IN PLACE (PLEASE ATTACH ADDITIONAL SHEETS IF NECESSARY).

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 a 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)

Do you have experience with EHR/EMR?	☐ **YES** ☐ **NO**

Name: _____

RELEASE & AUTHORIZATION

By signing below, I certify that all information 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 , 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**

Medical Doctor ASSOCIATES

4775 PEACHTREE INDUSTRIAL BLVD, SUITE 300
BERKELEY LAKE, GA 30092
1.800.780.3500
FAX: 770.246.0882

Name: _____

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
- ☐ CHEMICAL 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 - ENDOCARDIAL
- ☐ 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 PATIENTS ONLY
- ☐ VASECTOMIES – OWN & OTHER THAN OWN PATIENTS
- ☐ VERTEBORPLASTY
- ☐ WEIGHT CONTROL MEDICATION ____% OF PRACTICE
- ☐ GENERAL/SPINAL/CAUDAL ANESTHESIA
- ☐ OTHER 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)	____ % THORACIC	_____% ORTHOPEDIC (INCLUDING BACK)	
____% HAND	___ % PLASTIC (COSMETIC ENHANCEMENT ONLY)	_____% CARDIAC	
____% ORTHOPEDIC (NOT INCLUDING BACK)	____ % UROLOGY	_____% OTORHINOLARYNGOLOGY	
____% VASCULAR	___ % OPHTHALMOLOGY	____ % TRAUMATIC	_____% NEUROSURGERY
____ % OBSTETRICS	___ % GYNECOLOGY	____ %OTHER (DESCRIBE) _____	

Name: _____

D. IN THE LAST TEN (10) YEARS,

1. Have you discontinued major surgical procedures? If yes, list procedures and date discontinued: _____ ☐ **YES** ☐ **NO** ☐ **N/A**

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

2. Have you performed weight control surgery or prescribed weight control medication? ☐ **YES** ☐ **NO** ☐ **N/A**

3. If yes, what percentage of your practice (% of patient care) was devoted to prescribing anorectic drugs?

☐ 0<1% ☐ 1%-10% ☐ 11%-50% ☐ 0 >50%

4. If yes, what percentage of your practice (% of patient care) was devoted to performing weight control surgery?

☐ 0<1% ☐ 1%-10% ☐ 11%-50% ☐ 0 >50%

5. Do you have ownership interests in a weight control clinic? ☐ **YES** ☐ **NO** ☐ **N/A**

6. If yes, what is the name of the weight control clinic with which you are affiliated:_____

A. PLEASE FULLY EXPLAIN ANY "YES" ANSWERS:

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? If yes, please indicate the date(s):_____	☐ **YES** ☐ **NO**
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 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: _____

Print Name: _____

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, DEATH, LOSS OF MAJOR ORGAN FUNCTION, LOSS OF VISION, PERMANENT NEUROLOGICAL INJURY

☐ 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 (A Page 9 is required for each claim/suit reported)

*If making additional copies, please enter applicant's 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, that 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 healthcare 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 be limited to, the type of treatment and/or surgery; your involvement)

Name: _____

US Government Small Business Administration Subcontractor Survey & Attestation

☐ This form is not applicable (N/A) since I will be paid under my SSN

☐ If you are paid under a FEIN, but categorized as a large business, complete the top section and mark the N/A box under Classifications and sign the bottom of the form.

Please mark EVERY category that applies to your corporation using the definitions at the bottom of the form.

BUSINESS INFORMATION (PLEASE COMPLETE ALL BLANKS)		
BUSINESS NAME:		**TAX ID #:**
ADDRESS:		
CITY:	**STATE:**	**ZIP:**

CLASSIFICATIONS (PLEASE CHECK ALL THAT APPLY - IF NONE APPLY; CHECK HERE FOR N/A ☐)			
☐	**Small Business**	☐	**Small Disadvantaged Business**
☐	**Veteran-Owned Business**	☐	**Women-Owned Business**
☐	**Service-Disabled Veteran-Owned Business**	☐	**HUBzone Business**

- **"Small Business Concern"** means a concern, including its affiliates, that is independently owned and operated, not dominant in the field of operation which it is bidding in Government contracts or subcontracts, and meets the criteria and size standards published in Section 19.102 of the Federal Acquisition Regulation or 13 CFR, part 121. (For physicians - NAICS Classification Codes are Sector 62, Sub-sector 621 and small business is defined as less than $10 million in revenue).
- **"Veteran-Owned Concern"** means a small business concern that is at least 51 percent owned and controlled by a U.S. Veteran or Veterans as defined in 38 United States Code (U.S.C) 101 possessing a discharge other than dishonorable. The management and daily business operations of which are controlled by one or more veteran.
- **"Small-Disabled Veteran-Owned"** means a veteran with a disability that is service connected (as defined in section 101 (16) of title 38 U.S.C) and the small business is at least 51 percent owned and controlled by a US Veteran or Veterans possessing a discharge other than dishonorable. The management and daily business operations of which are controlled by one or more serviced-disabled veteran or, in the case of a veteran with permanent and sever disability, the spouse or permanent caregiver of such veteran.
- **"Small Disadvantaged Business Concern"** means a small business concern that (a) is at least 51 percent owned by one or more individuals who are both socially and economically disadvantaged, or a publicly owned business having at least 51 percent of its stock owned by one or more socially and economically disadvantaged individuals and (b) has its management and daily business controlled by one or more such individuals.
    - "Socially disadvantaged individuals" means individuals who have been subjected to racial or ethnic prejudice or cultural bias because of their identity as a member of a group without regard to their qualities as individuals.
    - "Economically disadvantaged individuals" means socially disadvantaged individuals whose ability to compete in the free enterprise system is impaired due to diminished opportunities to obtain capital credit as compared to others in the same line of business who are not socially disadvantaged. Individuals who certify that they are Black Americans, American Indians, Eskimos, Aleuts, Native Hawaiians or U.S. citizens whose origins are in India, Pakistan, Bangladesh, Japan, China, the Philippines, Viet Nam, Korea, Samoa, Guam, the U.S. Trust Territory of the Pacific Islands, North Mariana Islands, Laos, Cambodia or Taiwan are considered socially and economically disadvantaged.
- **"Small Women-Owned Business Concern"** means a small business concern that is at least 51 percent owned by a woman, or women, who are U.S. Citizens and who also control and operate it. Control in this context means actively involved in the day-to-day management.
- **"Historically Underutilized Business Zone (HUBZone)"** means a concern that appears on the list of HUBZone Small Business Concerns maintained by the Small Business Administration. Only companies certified by the SBA are eligible for HUBZone status.

I attest that the above information is accurate and true to the best of my knowledge.

Name _____ Signature _____ Date _____

Name: _____

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) ☐ AISLE ☐ WINDOW ☐ OTHER

MEAL REQUEST

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 MDA TRAVEL DEPARTMENT