New Jersey Universal Physician Application

(Please type or print)

SECTION 1

Personal Information

Physician Name (Last) (First) (MI) (Jr., Sr., etc.)		Professional Degree(s) *(MD, DO, DDS, DMD, DPM, DC)*	Social Security Number
Other Name Used	Years Associated with Former Name	Other Name Used	Years Associated with Former Name
Date of Birth (mm/dd/yyyy) / /	Gender ☐ Male ☐ Female	Are you eligible to work in the United States? ☐ Yes ☐ No	
Home Mailing Address	City	State	Zip Code

Practice Location Information

Type of Service Provided ☐ Primary Care Specialist ☐ Non-Primary Care Specialist			
Physician Group Name/Practice Name *(to appear in the directory)*	Group/Corporate Name *(as it appears on W-9)*, if different from Group Name/Practice Name		
Primary Office Mailing Address	City	State	Zip Code
Primary Office Telephone No.	Primary Office Fax No.	Primary Office E-mail Address	
Tax ID Number and Associated Individual Group Number and Name for This Location			
Are you currently practicing at the above location? ☐ Yes ☐ No	If No, what is your expected start date?		
Other Office Street Address	City	State	Zip Code
Telephone No.	Fax No.	E-mail Address	
Do you want this site listed in the Directory? ☐ Yes ☐ No	Tax ID Number and Associated Individual Group Number and Name for This Location		
Other Office Street Address	City	State	Zip Code
Telephone No.	Fax No.	E-mail Address	
Do you want this site listed in the Directory? ☐ Yes ☐ No	Tax ID Number and Associated Individual Group Number and Name for This Location		
Correspondence Office Street Address	City	State	Zip Code
Telephone No.	Fax No.	E-mail Address	

If you have additional offices, please submit an attachment containing the above information and check this box: ☐

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

License and Other Identification Numbers

(License Information - Include all license(s) and certifications in all States where you are currently or have previously been licensed.)

Type	State(s) of Registration	Do You Currently Practice In This State?	License/Certificate Number	Expiration Date	N/A
License		☐ Yes ☐ No			
License		☐ Yes ☐ No			
DEA Registration Certificate		☐ Yes ☐ No			
CDS Registration Certificate		☐ Yes ☐ No			
Other (CDS/DEA) (Specify)		☐ Yes ☐ No			

UPIN	National Provider ID (when available)	Are you a participating Medicare Provider?	Medicare Provider No.	Are you a participating Medicaid Provider?	Medicaid Provider No.

International Medical Graduates: Are you certified by the Educational Council for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No	If yes, ECFMG Number	ECFMG Issue Date

Medical Education

School Issuing Professional Degree (Medical, Dental, Chiropractic)	Degree	Attendance Dates	
Address	City	State/Country	Zip Code

If you have attended additional schools, please submit an attachment containing the above information and check this box: ☐

Post-Graduate Education ☐ Internship ☐ Fellowship ☐ Residency ☐ Teaching Appointment	Institution Name		
Address	City	State	Zip Code
Specialty	Start Date (Month/Year)	End Date (Month/Year)	

Post-Graduate Education ☐ Internship ☐ Fellowship ☐ Residency ☐ Teaching Appointment	Institution Name		
Address	City	State	Zip Code
Specialty	Start Date (Month/Year)	End Date (Month/Year)	

Post-Graduate Education ☐ Internship ☐ Fellowship ☐ Residency ☐ Teaching Appointment	Institution Name		
Address	City	State	Zip Code
Specialty	Start Date (Month/Year)	End Date (Month/Year)	

If you completed additional training, please submit an attachment containing the above information and check this box: ☐

Other Graduate Level Education for Which a Degree Was Obtained - Type of Program (Psychology, Public Health, MBA, etc.)	Institution Name		
Address	City	State	Zip Code
Degree Obtained	Date of Graduation (Month/Year)		

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Professional/Medical Specialty Information

Primary Specialty	Board Certified? ☐ Yes ☐ No	Name of Certifying Board
Initial Certification Date	Recertification Date (s) *(if applicable)*	Expiration Date *(if applicable)*

Do you wish to be listed in the directory under this specialty?

HMO ☐ Yes ☐ No
PPO ☐ Yes ☐ No
POS ☐ Yes ☐ No

If not Board Certified, indicate any of the following that apply:

☐ I have taken exam, results pending for: _____ (board)
☐ I am intending to sit for the Boards on: _____ (date)
☐ I am not planning to take the Boards.

Secondary Specialty	Board Certified? ☐ Yes ☐ No	Name of Certifying Board
Initial Certification Date	Recertification Date (s) *(if applicable)*	Expiration Date *(if applicable)*

Do you wish to be listed in the directory under this specialty?

HMO ☐ Yes ☐ No
PPO ☐ Yes ☐ No
POS ☐ Yes ☐ No

If not Board Certified, indicate any of the following that apply:

☐ I have taken exam, results pending for: _____ (board)
☐ I am intending to sit for the Boards on: _____ (date)
☐ I am not planning to take the Boards.

Additional Specialty	Board Certified? ☐ Yes ☐ No	Name of Certifying Board
Initial Certification Date	Recertification Date (s) *(if applicable)*	Expiration Date *(if applicable)*

Do you wish to be listed in the directory under this specialty?

HMO ☐ Yes ☐ No
PPO ☐ Yes ☐ No
POS ☐ Yes ☐ No

If not Board Certified, indicate any of the following that apply:

☐ I have taken exam, results pending for: _____ (board)
☐ I am intending to sit for the Boards on: _____ (date)
☐ I am not planning to take the Boards.

List Additional Areas of Professional Practice, Interest or Focus (HIV/AIDS, etc.)

Hospital Affiliations and Privileges

Do you have hospital privileges? ☐ Yes ☐ No

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

If you have privileges, please complete the section below. Include all hospitals where you have privileges.

Primary Hospital where you have Admitting Privileges			Telephone Number
Address	City	State	Zip Code
Full Unrestricted Privileges ☐ Yes ☐ No	Type of Privileges	Are Privileges Temporary? ☐ Yes ☐ No	Of the total admissions to all hospitals in the past year, what percentage is to this specific hospital?
Other Hospital Where you Have Privileges			Telephone Number
Address	City	State	Zip Code
Full Unrestricted Privileges ☐ Yes ☐ No	Type of Privileges	Are Privileges Temporary? ☐ Yes ☐ No	Of the total admissions to all hospitals in the past year, what percentage is to this specific hospital?
Other Hospital Where you Have Privileges			Telephone Number
Address	City	State	Zip Code
Full Unrestricted Privileges ☐ Yes ☐ No	Type of Privileges	Are Privileges Temporary? ☐ Yes ☐ No	Of the total admissions to all hospitals in the past year, what percentage is to this specific hospital?
Additional Hospital Where you Have Privileges			Telephone Number
Address	City	State	Zip Code
Full Unrestricted Privileges ☐ Yes ☐ No	Type of Privileges	Are Privileges Temporary? ☐ Yes ☐ No	Of the total admissions to all hospitals in the past year, what percentage is to this specific hospital?

If you have additional hospital affiliations, please submit an attachment containing the above information and check this box: ☐

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

List all other hospitals where you have previously had privileges.			
Hospital Name		Dates of Affiliation	
Address	City	State	Zip Code
Hospital Name		Dates of Affiliation	
Address	City	State	Zip Code

If you have other previous hospital affiliations, please submit an attachment containing the above information and check this box: ☐

Work History

Include chronological work history since completion of training.			
Practice/Employer Name		Start Date/End Date	
Address	City	State	Zip Code
Practice/Employer Name		Start Date/End Date	
Address	City	State	Zip Code
Practice/Employer Name		Start Date/End Date	
Address	City	State	Zip Code
Practice/Employer Name		Start Date/End Date	
Address	City	State	Zip Code

For additional work history, please submit an attachment containing the above information and check this box: ☐

Please provide an explanation of any gaps greater than six months in each work history.	
Date	Explanation
Date	Explanation
Are you currently on active military duty or on military reserve? ☐ Yes ☐ No	

References

Please provide three professional references that are not partners in your own group practice and are not relatives.	
Name	Street Address City, State, Zip Code

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Professional Liability Insurance Coverage

Are you self-insured? ☐ Yes ☐ No

Name of Current Malpractice Insurance Carrier or Self-Insured Entity		Telephone Number	Effective Date	Expiration Date
Address		City	State	Zip Code
Policy Number	Amount of Coverage per Occurrence	Amount of Coverage Aggregate	Type of Coverage ☐ Individual ☐ Shared	Length of Time with Carrier
Name of Previous Malpractice Insurance Carrier or Self-Insured Entity		Telephone Number	Effective Date	Expiration Date
Address		City	State	Zip Code
Policy Number	Amount of Coverage per Occurrence	Amount of Coverage Aggregate	Type of Coverage ☐ Individual ☐ Shared	Length of Time with Carrier

Status/Role in Practice

☐ Owner ☐ Partner ☐ Employee ☐ Officer ☐ Shareholder

Interests in Outside Clinical Lab(s)

If you own/co-own, or have interests in any other outside clinical lab, please fill in below:

Legal Billing Name	TIN (Attach copy of W-9)	Clinical Description

Please provide a summary pattern for this business:

Office Coverage

List names of colleague(s) providing regular coverage and his/her specialty(ies).

Name	Provider Specialty

Partners

List full names of all partners in your practice (attach list for large group).

Name (Last, First, MI)	Name (Last, First, MI)

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Other Practice Information (specify for each site)

Site 1	Site 2
Office Address:	Office Address:
Type of Practice: ☐Solo ☐Single Specialty Group ☐Multi-Specialty Group	Type of Practice: ☐Solo ☐Single Specialty Group ☐Multi-Specialty Group
Office Manager or Business Office Staff Contact:: Name: _____ Telephone No.: _____ Fax No.: _____	Office Manager or Business Office Staff Contact:: Name: _____ Telephone No.: _____ Fax No.: _____
Credentialing Contact (if different from above): Name: _____ Telephone No.: _____ Fax No.: _____ E-mail: _____ Address: _____ City: _____ State: _____ Zip: _____	Credentialing Contact (if different from above): Name: _____ Telephone No.: _____ Fax No.: _____ E-mail: _____ Address: _____ City: _____ State: _____ Zip: _____
Billing Information: Billing Rep. Name: _____ Address: _____ City: _____ State: _____ Zip: Telephone No.: _____ Fax No.: _____ E-mail: _____ Dept. Name if Hosp.-Based: _____ Check should be payable to _____ Do you have capability of electronic billing? ☐Yes ☐No	Billing Information: Billing Rep. Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Telephone No.: _____ Fax No.: _____ E-mail: _____ Dept. Name if Hosp.-Based: _____ Check should be payable to _____ Do you have capability of electronic billing? ☐Yes ☐No

Office Business Hours (hours patients are seen):

Day	No Office Hours	Morning	Afternoon	Evening
MON	☐			
TUES	☐			
WED	☐			
THUR	☐			
FRI	☐			
SAT	☐			
SUN	☐			

Office Business Hours (hours patients are seen):

Day	No Office Hours	Morning	Afternoon	Evening
MON	☐			
TUES	☐			
WED	☐			
THUR	☐			
FRI	☐			
SAT	☐			
SUN	☐			

After hours, back office phone number for health plan business use only:	After hours, back office phone number for health plan business use only:
Do you provide 24 hour/7 day a week phone coverage for this site? ☐ Yes ☐ No If yes, indicate type: ☐ Answering service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions	Do you provide 24 hour/7 day a week phone coverage for this site? ☐ Yes ☐ No If yes, indicate type: ☐ Answering service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions

(Continue on next page.)

Other Practice Information (specify for each site)

(Continued from previous page.)

Site 1, Continued	Site 2, Continued
Do you accept new patients into the practice? ..... ☐Yes ☐No -All new patients?..... ☐Yes ☐No -Existing patients with change of payor?..... ☐Yes ☐No -New patients from physician referral?..... ☐Yes ☐No -New Medicare patients? ..... ☐Yes ☐No -New Medicaid patients?..... ☐Yes ☐No If this information varies by health plan, provide explanation:	Do you accept new patients into the practice? ..... ☐Yes ☐No -All new patients?..... ☐Yes ☐No -Existing patients with change of payor?..... ☐Yes ☐No -New patients from physician referral?..... ☐Yes ☐No -New Medicare patients? ..... ☐Yes ☐No -New Medicaid patients?..... ☐Yes ☐No If this information varies by health plan, provide explanation:
Are there any practice limitations? ☐ Yes ☐ No If yes, indicate limitations below: Gender: ☐Male Only ☐Female Only ☐N/A Patient Age Limitation (List Ages): ☐N/A List Other Limitations:	Are there any practice limitations? ☐ Yes ☐ No If yes, indicate limitations below: Gender: ☐Male Only ☐Female Only ☐N/A Patient Age Limitation (List Ages): ☐N/A List Other Limitations:
Do mid-level practitioners such as nurse practitioners, physician assistants, midwives, social workers or other non-physician providers care for patients in your practice? ☐Yes ☐No If yes, provide the following information for each staff member: Name: Professional Designation: State License Number: Name: Professional Designation: State License Number:	Do mid-level practitioners such as nurse practitioners, physician assistants, midwives, social workers or other non-physician providers care for patients in your practice? ☐Yes ☐No If yes, indicate limitations below: Name: Professional Designation: State License Number: Name: Professional Designation: State License Number:
Please attach a list of any additional mid-level practitioners.	*Please attach a list of any additional mid-level practitioners.*
Non-English Languages spoken: by health care professional: by office personnel: Are interpreters available? ☐Yes ☐No If yes, specify languages:	Non-English Languages spoken: by health care professional: by office personnel: Are interpreters available? ☐Yes ☐No If yes, specify languages:
Does this office meet ADA accessibility standards? ☐Yes ☐No	Does this office meet ADA accessibility standards? ☐Yes ☐No
Does this site provide handicapped accessibility for each of the following: Building ☐Yes ☐No Parking ☐Yes ☐No Restroom ☐Yes ☐No Other:	Does this site provide handicapped accessibility for each of the following: Building ☐Yes ☐No Parking ☐Yes ☐No Restroom ☐Yes ☐No Other:
Does this site have other services for the disabled? ☐Yes ☐No If yes, indicate type: Text Telephony - TTY ☐Yes ☐No American Sign Language-ASL ☐Yes ☐No Mental/Physical Impairment Services ☐Yes ☐No Other:	Does this site have other services for the disabled? ☐Yes ☐No If yes, indicate type: Text Telephony - TTY ☐Yes ☐No American Sign Language-ASL ☐Yes ☐No Mental/Physical Impairment Services ☐Yes ☐No Other:

(Continue on next page.)

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Other Practice Information (specify for each site)

(Continued from previous page.)

Site 1, Continued	Site 2, Continued
Is this site accessible by public transportation?	Is this site accessible by public transportation?
☐Yes ☐No	☐Yes ☐No
Bus ☐Yes ☐No	Bus ☐Yes ☐No
Subway ☐Yes ☐No	Subway ☐Yes ☐No
Regional Train ☐Yes ☐No	Regional Train ☐Yes ☐No
Other: _____	Other: _____
Does this site provide childcare services? ☐Yes ☐No	Does this site provide childcare services? ☐Yes ☐No
Does this office qualify as a minority business enterprise? ☐Yes ☐No	Does this office qualify as a minority business enterprise? ☐Yes ☐No
Do you or does someone in your office have the following certifications? *(Indicate for each office location.)*	Do you or does someone in your office have the following certifications? *(Indicate for each office location.)*
Yes No Exp.Date	Yes No Exp.Date
BLS (Basic Life Support) ☐ ☐ _____	BLS (Basic Life Support) ☐ ☐ _____
ACLS (Advanced Cardiac Life Support) ☐ ☐ _____	ACLS (Advanced Cardiac Life Support) ☐ ☐ _____
ALSO (Advanced Life Support in OB) ☐ ☐ _____	ALSO (Advanced Life Support in OB) ☐ ☐ _____
PALS (Pediatric Advanced Life Support) ☐ ☐ _____	PALS (Pediatric Advanced Life Support) ☐ ☐ _____
ATLS (Advanced Trauma Life Support) ☐ ☐ _____	ATLS (Advanced Trauma Life Support) ☐ ☐ _____
NALS (Neonatal Advanced Life Support) ☐ ☐ _____	NALS (Neonatal Advanced Life Support) ☐ ☐ _____
CPR (Cardio-Pulmonary Resuscitation) ☐ ☐ _____	CPR (Cardio-Pulmonary Resuscitation) ☐ ☐ _____
Does your site provide any of the following services on site? *(Indicate for each office location.)*	Does your site provide any of the following services on site? *(Indicate for each office location.)*
Laboratory Services ☐Yes ☐No	Laboratory Services ☐Yes ☐No
Certificate of Participation from CLIA or another accrediting/certifying program [AAFP, COLA, CAP, Medical Laboratory Evaluation (MLE)] Program ☐Yes ☐No	Certificate of Participation from CLIA or another accrediting/certifying program [AAFP, COLA, CAP, Medical Laboratory Evaluation (MLE)] Program ☐Yes ☐No
If yes, list program: _____	If yes, list program: _____
Radiology Services ☐Yes ☐No	Radiology Services ☐Yes ☐No
X-Ray Certification ☐Yes ☐No	X-Ray Certification ☐Yes ☐No
If yes, include type: _____	If yes, include type: _____
EKG's ☐Yes ☐No	EKG's ☐Yes ☐No
Care of Minor Lacerations ☐Yes ☐No	Care of Minor Lacerations ☐Yes ☐No
Pulmonary Function Testing ☐Yes ☐No	Pulmonary Function Testing ☐Yes ☐No
Allergy Injections ☐Yes ☐No	Allergy Injections ☐Yes ☐No
Allergy Skin Testing ☐Yes ☐No	Allergy Skin Testing ☐Yes ☐No
Office Gynecology (Routine Pelvic/Pap) ☐Yes ☐No	Office Gynecology (Routine Pelvic/Pap) ☐Yes ☐No
Drawing Blood ☐Yes ☐No	Drawing Blood ☐Yes ☐No
Age Appropriate Immunizations ☐Yes ☐No	Age Appropriate Immunizations ☐Yes ☐No
Flexible Sigmoidoscopy ☐Yes ☐No	Flexible Sigmoidoscopy ☐Yes ☐No
Tympanometry/Audiometry Screening ☐Yes ☐No	Tympanometry/Audiometry Screening ☐Yes ☐No
Asthma Treatment ☐Yes ☐No	Asthma Treatment ☐Yes ☐No
Osteopathic Manipulation ☐Yes ☐No	Osteopathic Manipulation ☐Yes ☐No
IV Hydration/Treatment ☐Yes ☐No	IV Hydration/Treatment ☐Yes ☐No
Cardiac Stress Tests ☐Yes ☐No	Cardiac Stress Tests ☐Yes ☐No
Physical Therapy ☐Yes ☐No	Physical Therapy ☐Yes ☐No
Additional Office Procedures Provided (incl. surgical procedures)	Additional Office Procedures Provided (incl. surgical procedures)
Is anesthesia administered in your office? ☐Yes ☐No	Is anesthesia administered in your office? ☐Yes ☐No
If Yes, what class or category of anesthesia do you use?	If Yes, what class or category of anesthesia do you use?
_____	_____
Who administers it?	Who administers it?
_____	_____

For additional office sites, please submit an attachment containing the above information and check this box: ☐

Patient Scheduling

What is patient wait time for emergency care? .....
What is patient wait time for urgent care? .....
What is patient wait time for symptomatic care? .....
What is patient wait time for scheduling routine visits? .....
What is patient wait time for scheduling routine care? .....
What is average wait time for patients between waiting room and examination?
What is average wait time in minutes for returning a patient's call? .....

Required Attachments or Supplemental Information

Please attach hard copy or scanned documents of the following:

- Copy(ies) of DEA registration certificate(s)
- Copy of state Controlled Dangerous Substance (CDS) registration certificate(s)
- Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and provider's name
- Copy(ies) of W-9(s) for verification of each tax identification number used
- Copy of workers compensation certificate of coverage, if applicable

SECTION 2 - DISCLOSURE QUESTIONS

Please answer each question and include an explanation for any question answered "Yes."

Licensure

1. Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board? ☐ Yes ☐ No
2. Have you ever received a reprimand or been fined by any state licensing board? ☐ Yes ☐ No

Hospital Privileges and Other Affiliations

3. Have your clinical privileges at any hospital or healthcare institution 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 records 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? ☐ Yes ☐ No
4. Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? ☐ Yes ☐ No
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)? ☐ Yes ☐ No

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? ☐ Yes ☐ No
7. Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? ☐ Yes ☐ No
8. Have any of your board certifications or eligibility ever been revoked? ☐ Yes ☐ No
9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? ☐ Yes ☐ No

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

DEA or CDS Certification/Authorization

10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished? ☐ Yes ☐ No

Medicare, Medicaid or Other Governmental Program Participation

11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified, subject to a recovery action or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs? ☐ Yes ☐ No

Other Sanctions or Investigations

12. Are you currently or have you ever been 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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

14. Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? ☐ Yes ☐ No

15. Has a patient, employee, or co-worker ever accused you of sexual harassment or other illegal misconduct that resulted in an investigation, sanction or other formal action? ☐ Yes ☐ No

16. Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

Malpractice Claims History

19. Have you ever had any malpractice actions (pending, settled, dropped, dismissed, arbitrated, mediated or litigated)? If yes, provide information for each case on the attached form located at the end of the Disclosure questions (list all separately). ☐ Yes ☐ No

For any malpractice actions, please complete addendum and check this box: ☐

Criminal/Civil History
(Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all relevant circumstances, including the nature of the crime.)

20. Have you ever been arrested, charged or indicted for, convicted of, pled guilty to, or pled nolo contendere to any felony, crime or other offense in the last ten years or been found liable or responsible for or named as a defendant in any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional? ☐ Yes ☐ No

21. Have you ever been arrested, charged or indicted for, convicted of, pled guilty to, or pled nolo contendere to any felony, crime or other offense in the last ten years or been found liable or responsible for or been named as a defendant in any civil offense that alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? ☐ Yes ☐ No

22. Have you ever been court-martialed for actions related to your duties as a medical professional? ☐ Yes ☐ No

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.) ☐ Yes ☐ No

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? ☐ Yes ☐ No

25. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients? ☐ Yes ☐ No

26. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? ☐ Yes ☐ No

Please provide information below for Malpractice Actions indicated for Disclosure Question #19.

Date of occurrence: _____

Date claim was filed: _____

Claim/case status: _____

_____

Professional liability carrier involved: _____

Address: _____

Telephone Number: _____

Policy Number: _____

Amount of award or settlement and amount paid: _____

Method of resolution: ☐Dismissed ☐Settled (with prejudice) ☐Settled (without prejudice)
☐Judgment for defendant(s) ☐Judgment for plaintiff(s) ☐Mediation or arbitration

Description of allegations: _____

_____

_____

_____

Were you primary defendant or co-defendant? _____

Number of other co-defendants: _____

Your involvement in case (attending, consulting, etc.): _____

Description of alleged injury to the patient: _____

_____

_____

_____

To the best of your knowledge, is this case included in the National Practitioner Data Bank (NPDB)? ☐Yes ☐No

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Please provide information below for any Disclosure Questions in Section II answered "Yes."	
Question No.	Explanation

Provider Initials: _____ Date: _____

SECTION 3 - AUTHORIZATION, ATTESTATION AND RELEASE

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as "Participation") at or with _____ (indicate managed care company(s) to which you are applying) (hereinafter, individually referred to as the "Entity"), and any of the Entity's affiliated entities, 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 the Entity for determining initial and ongoing eligibility for Participation. Each Entity 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 each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorizations

Investigation Concerning Application for Participation: I hereby authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (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 the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

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 the Entity 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, the Entity. 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.

Release and Exchange of Disciplinary Information: I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Provider Initials: _____ Date: _____

Releases

Release from Liability. I release from all liability and hold harmless any Entity, 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 the Entity, 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 any Entity, 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 such Entity, 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 the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity 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 at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. 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 the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. 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.

Attestation

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that the information provided on this application may be shared with appropriate State and federal agencies.

I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further understand and agree that submitting false, misleading or incomplete information may result in the imposition of administrative, civil and/or criminal sanctions, in accordance with State and federal law.

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Name (Print or Type)	Social Security Number
Signature	Date