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PHYSICIAN QUESTIONNAIRE

(Circle One)

1. Have your hospital privileges ever been refused, revoked, suspended, or reduced? Y N

2. Are you currently under review or have you ever been disciplined by any State Board or Medical Examiners or by any Professional Conduct Board? (If yes, please Complete exhibit Two) Y N

3. Have any malpractice suits, arbitrations or other proceedings ever been instituted against you? (If Yes, please complete Exhibit One) Y N

4. Has your license to practice medicine in any jurisdiction (state or county) ever been revoked, suspended, or subject to probation or any conditions or limitations? (If yes, please complete Exhibit Two) Y N

5. Has your DEA certificate ever been suspended or otherwise limited? (If yes, please complete Exhibit Two) Y N

6. Are you an owner, partner, investor, or do you have a business interest in any clinical laboratory, diagnostic, or testing center, surgicenter, or other business dealing with the provision of health services, equipment or supplies? (If yes, please include the following information: Name of organization, tax I.D. number, address, phone number, type of organization, nature of business interest, and percent of ownership/investment) Y N

7. Do you have any physical or mental health condition, treated or untreated? (if yes, please explain) Y N

8. Do you have a chemical dependency/substance abuse problem, treated or untreated? (If yes, please attach explanation) Y N

9. To the best of your knowledge, has any information pertaining to you ever been Reported to the National Practitioner Data Bank? (If yes, please attach a copy of the reports) Y N

10. Have you ever been convicted of any a felony or misdemeanor? (other than Minor traffic violations) Y N

Printed Name____

Signature ____ Date__________________

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EXHIBIT ONE

MALPRACTICE DETAILS

Please attach a copy of the actual legal document or complete the following. If you have been involved in more than one malpractice suit, please photocopy this form and complete one copy per occurrence.

File number:________________________________

Date of summons and complaint:________________________________

Date of incident:________________________________

Plaintiff(s) name:________________________________

Defendant(s) name:________________________________

Insurance company involved:________________________________

Policy Number:________________________________

Complaint:________________________________

Stage of suit:________________________

Date expected to be resolved:________________________

Court Date:________________________

Detailed outcome of suit (include dollar amount of any settlement):________________

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EXHIBIT TWO

DISCIPLINARY ACTIONS

Please describe any disciplinary actions taken by the State Board of Medical Examiners, Professional Conduct Board, medical organization, State or County agency. If you have been disciplined more than once, please photocopy this form and complete one form per occurrence.

Date of original action:____

Nature of misconduct:____

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Agency(ies) taking action:____

Action taken:____

Specific restriction or orders with which to comply:___________________________________

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Subsequent action and date:____

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