

CONTINUING MEDICAL EDUCATION:

List all courses completed during the previous year:

PROFESSIONAL LIABILITY INSURANCE:

Insurance Company Name:

Address:

Maximum \$ Per Occurrence:

| Maximum \$ Per Aggregate:

Policy Number:

| Agent's Name:

Provide the names and addresses of your professional liability carriers for the past 5 years, if different from your current carrier:

Have you ever been denied professional liability insurance?

Yes No (if Yes, explain):

Has your professional liability insurance ever been terminated?

Yes No (if Yes, explain):

PROFESSIONAL LICENSING: (Attach a copy of all certificates/professional licenses)

List the State(s) in which you hold or have held a medical license:

(State)	(License No.)	(Date Issued)	(Expiration Date)

If extra space is needed, please attach additional sheet(s).

SPECIALTY BOARD CERTIFICATIONS: (Attach a copy of your certification(s))

1.
(Specialty Board) (Date of Certification) (Date of Expiration)

2.
(Specialty Board) (Date of Certification) (Date of Expiration)

3.
(Specialty Board) (Date of Certification) (Date of Expiration)

ACADEMIC APPOINTMENTS (Start with most recent):

1.
(Institution) (Position) (Dates)

2.
(Institution) (Position) (Dates)

3.
(Institution) (Position) (Dates)

CURRENT HOSPITAL AFFILIATIONS AND ADMITTING PRIVILEGES:

Please attach a copy of the declaration of privileges for each hospital or facility.

(Facility) (Location) (Status) (Dates)

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If extra space is needed, please attach additional sheet(s).

CURRENT EMPLOYMENT (Include self, corporate, practice and other):

Company or Professional Corporation: Federal Tax ID #:

Classify your company or corporation:
Hospital Private Practice Group Practice University Other (Explain other):

Address: Phone #:
Fax #:
Contact Person:

Days that you can be reached at this address: S M T W R F S None

Your title within your company or corporation:

Classify your primary medical work: Practitioner Researcher/Teacher Other (Explain other)

CURRENT MEDICAL PRACTICE:

Percentage of time devoted to medical practice:

Subspecialty or focus of practice: (optional)

Medical Areas that you feel comfortable reviewing:

- 1.
- 2.
- 3.



MEDICAL EMPLOYMENT HISTORY (List most current first):

1. EMPLOYER: ADDRESS: DATES:	POSITION: DUTIES:
2. EMPLOYER: ADDRESS: DATES:	POSITION: DUTIES:
3. EMPLOYER: ADDRESS: DATES:	POSITION: DUTIES:
4. EMPLOYER: ADDRESS: DATES:	POSITION: DUTIES:
5. EMPLOYER: ADDRESS: DATES:	POSITION: DUTIES:

Please attach an explanation of gaps in employment greater than 6 months.

CONFLICTS OF INTEREST (List direct or familial relationships):

List each current or planned affiliation with any health insurer utilization review firm, provider network or drug/device supply company. (CHDR defines affiliation as an owner, shareholder, partner, officer, director, employee, consultant, contracted provider or a familial relationship to any of the above. Ownership of more than 5% or any commission, royalty or similar arrangement should be listed.)

1. (Entity Name)	(Affiliation)
2. (Entity Name)	(Affiliation)
3. (Entity Name)	(Affiliation)

If extra space is needed, please attach additional sheet(s).

QUESTIONS:

If the answer to any of the following is “Yes”, then please supply a detailed explanation on a separate sheet.

YES NO

 A. Has your license to practice medicine or prescribe controlled substances in any jurisdiction ever been revoked, suspended, denied or voluntarily suspended, or is any such action or other disciplinary or misconduct action pending or withdrawn?

 B. Have clinical privileges or staff membership at any hospital ever been denied, revoked, suspended, reduced, not renewed, voluntarily surrendered or withdrawn or is any such action pending or withdrawn.

 C. Has membership in any medical organization ever been suspended, revoked, limited or denied, or is any such action pending or withdrawn?

 D. Are there any pending administrative agency or court cases, or administrative agency or court decisions, judgment or settlements in which you are alleged to have violated, or was found guilty of violating any criminal law? (Exclude minor traffic violations)

 E. Have any professional liability lawsuits ever been initiated against you?

 F. Has any judgment or settlement been made against you in any professional liability case or is any case pending?

 G. Are there any prior or pending government agency or third party payer proceedings or litigation challenging or sanctioning your patient admission, treatment, discharge, charging, collection or utilization practices, including but not limited to Medicare/Medicaid fraud and abuse proceedings and convictions?

If the answer to question D, E, F, or G is “Yes”, then, as part of the full detailed explanation required, please give the name of the court in which the lawsuit was brought, the caption and docket number of the case, the name and address of the attorney defending you, or the substance of the allegations in the lawsuit or proceeding.

If extra space is needed, please attach additional sheet(s).

REPRESENTATIONS

I certify that the information on this application form is, to my knowledge, accurate, complete and true.

I understand that any misstatements in or omissions from this application constitute cause for non-eligibility or termination as a consultant.

I hereby release from liability any person or entity who provides information to MAXIMUS Federal Services concerning my application.

I hereby authorize MAXIMUS Federal Services and its representatives to consult with and solicit information from whatever third parties may have information bearing on the application and consent to the release and inspection of any such information.

This authorization shall be valid during the time my application is pending with MAXIMUS Federal Services, and shall be valid during each year thereafter while I maintain a consulting relationship with MAXIMUS Federal Services.

A photocopy of the authorization will be as valid as the original.

I certify that my mental and physical health status does not present any impediment to the treatment of patients and acting as a consultant to MAXIMUS Federal Services

Should there be any changes in my licensure, hospital affiliation(s), insurance coverage, and/or address, I will immediately notify MAXIMUS Federal Services of the change.

Consultant Signature

Date

Print Name

Mail the completed application to:

Kim Donselaar, Federal Services

50 Square Drive, Suite 210, Victor, New York 14564-1099

NOTE: INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

If extra space is needed, please attach additional sheet(s).