Carisk® PARTNERS

Physician Application

I. GENERAL INFORMATION

Physician Information:

Name: (Last) ______________________(First) ______________________(MI) ________

Male Female Date of Birth: ________________SS #: ______________________

Specialty: ______________________Degree: ______________________

State of Licensure: ______________________License #: ______________Exp. Date: __________

State of Licensure: ______________________License #: ______________Exp. Date: __________

State of Licensure: ______________________License #: ______________Exp. Date: __________

DEA # (if applicable): ______________________CDS # (if applicable): ______________________

NPI #: ______________________Workers Compensation # (if applicable): ______________________

UPIN # (if applicable): ______________________Email Address: ______________________

II. PRIMARY PRACTICE INFORMATION (PLEASE LIST ADDITIONAL PRACTICES UNDER SECTION VIII ON PAGE 4)

Practice Name: ______________________Start Date at Practice: __________To: Present

Street Address: ______________________City: ____________State: __________Zip: __________

Phone: ______________________Fax: ______________________

Practice Tax ID #: ______________________

III. EDUCATION & TRAINING

Medical Education:

Institution Name: ______________________

City: ______________________State: ____________Country: ______________

Graduation Date: ________________Dates Attended (mo./Yr.) From: __________To: __________

Internship/Post-Graduate Study:

Institution Name: ______________________

City: ______________________State: ____________Country: ______________

Dates Attended (mo./Yr.) From: ____________To: ____________

Specialty/Program: ______________________Type of Program Rotating Straight

Residency:

Institution Name: ______________________

City: ______________________State: ____________Country: ______________

Dates Attended (mo./Yr.) From: ____________To: ____________

Specialty/Program: ______________________Was Program Completed? Yes No

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Fellowship:

Institution Name: ______________________________

City: ______________________ State: __________ Country: __________

Dates Attended (mo./Yr.) From: __________ To: __________

Specialty/Program: ______________________ Was Program Completed? Yes No

IV. SPECIALTIES (**MUST BE BOARD CERTIFIED IN PRACTICING SPECIALTY**)

Specialties: ______________________ Certified Eligible Date: __________

______________________ Certified Eligible Date: __________

______________________ Certified Eligible Date: __________

______________________ Certified Eligible Date: __________

V. PROFESSIONAL LIABILITY INSURANCE

Please provide names, addresses, policy numbers, coverage limits, and dates for current and all past malpractice insurance carriers (minimum 5 year history)

Present Carrier: ______________________________

Primary Insurance Company Name: ______________________________

Address: ______________________________

City: ______________________ State: __________ Zip: __________ Phone: __________

Annual Premium: ______________________ Policy Number: ______________________

Coverage Limits: ______________________ Coverage Date From: __________ Date To: __________

Type of Coverage: Claims Made Occurrence Self Insurance through Hospital Policy

PLEASE SEE PAGE 3 FOR PROFESSIONAL LIABILITY HISTORY

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VI. PROFESSIONAL LIABILITY HISTORY

Please list all past or current professional liability claims or lawsuits which have been filed against you. (photocopy this page as needed and submit information on each claim/lawsuit

Date of Occurence: ______________________ Dates Claims were filed: ______________________

Professional Liability Carrier Involved: ____

Patient Name: ______________________ Name of Claimant/Plaintiff: ______________________

Describe your role in the claim/lawsuit: Primary Defendant Co-defendant

Describe the allegations against you: ____

____

____

Describe the alleged injury to the patient: ____

____

____

____

Identify all other defendants: ____

____

____

____

Has the claimant/plaintiff filed suit in court? Yes No

Case Number: ______________ State Court State: __________ County/Parish: ______________

Case Number: ______________ Federal Court (US District Court) District: ______________

Present Status of the claim or case:

- The case or claim is still pending
- The case was dismissed by the court
- The claimant/plaintiff voluntarily withdrew the claim/lawsuit
- The claimant/plaintiff voluntarily dismissed me from the claim/lawsuit
- Verdict of judgment for plaintiff was entered in the amount of $ ____________
  The portion of the verdict or judgment attributed to me was $ ____________
- Case or claim was settled for $ ____________
  The portion of the settlement which was paid on my behalf was $ ____________

Identify your attorney for this claim/lawsuit:

Name: ______________________________ Firm: ______________________________

Street: ______________________________ City: ______________ State: ______ Zip: ______

VII. HOSPITAL AFFILIATIONS

Current Appointments:

Primary Admitting Hospital: ______________________ From: __________ To: __________

Type of Appointment: ______________________ Specialty: ______________________

Any Restrictions: Yes No If yes, please describe: ______________________

Additional Appointments:

Name	Appointment	Specialty	From/To	Restrictions

VIII. ADDITIONAL INFORMATION

Please provide any additional information or comments regarding any of the items in this application.

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X. ATTESTATION & CREDENTIALS VERIFICATION RELEASE

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended (even if the suspension was stayed) or revoked, either voluntarily or involuntarily? .... Yes No
2. Have you ever been reprimanded, disciplined, counseled or been subject to similar action by any state-licensing agency with respect to your license or practice? .... Yes No
3. Has your DEA or state controlled substances registration ever been restricted, limited, suspended (even if the suspension was stayed), or revoked, either voluntarily or involuntarily? .... Yes No
4. Are you currently under any investigation with respect to your DEA or state controlled substance registration? .... Yes No
5. Have you ever been denied hospital privileges or have you ever had any hospital privileges revoked, suspended (even if the suspension was stayed), reduced or non-renewed? .... Yes No
6. Have you ever voluntarily relinquished or voluntarily limited any hospital privileges? .... Yes No
7. Have any disciplinary proceedings ever been instituted against you or are any disciplinary actions now pending with respect to your hospital privileges or your license? .... Yes No
8. Have you ever been denied participation in Medicare, Medicaid or any other governmental or quasigovernmental health-related program? .... Yes No
9. Have you ever been reprimanded, censured, excluded, suspended (even if the suspension was stayed), barred or disqualified from participating in Medicare, Medicaid or any other governmental or quasigovernmental health-related program? .... Yes No
10. Have you ever been requested to resign, withdraw or terminate your position with a medical partnership, professional association, health maintenance organization, medical practice, either public or private? .... Yes No
11. Have any complaints ever been filed against you with a medical society or licensing authority? .... Yes No
12. Have any professional liability judgments ever been entered against you? .... Yes No
13. Have any professional liability claim settlements, not involving litigation or arbitration, ever been paid by you or paid on your behalf? .... Yes No
14. Have you ever been denied professional liability insurance coverage or had your professional liability insurance coverage cancelled by your carrier? .... Yes No
15. Have you ever been convicted of a crime or do you have any criminal charges pending other than for minor traffic offenses? .... Yes No
16. Have you ever been refused participation in the network of a managed care organization (HMO or PPO) or been disciplined by or terminated from such a plan or organization? .... Yes No
17. Has any information pertaining to you ever been reported to the National Practitioner Data Bank (NPDB)? .... Yes No
18. Is your physical or mental health such that it may impair your ability to practice with the scope of privileges for which you have applied with or without reasonable accommodation? .... Yes No
19. Does your current use (within the past two years) of alcohol or other chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and accuracy? .... Yes No
20. Are the limitation or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? .... Yes No
21. Are the limitation or impairments caused by your medical condition reduced or ameliorated because of field of practice, the setting or the manner in which you have chosen to practice? .... Yes No
22. Are you currently (within the past two years) using illegal drugs or controlled or dangerous substances? .... Yes No
23. If you answered yes to the above question, are you currently participating in a supervised rehabilitation program or professioal assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? .... Yes No
24. Are there any reasons for any inability to perform the essential functions of you position without accommodation? .... Yes No
25. Have any disciplinary actions of any sort even been taken against you by an ethics committee, professional association or educating/training institution? .... Yes No
26. Have you ever been the object of an administrative, civil or criminal complaint or investigation regarding sexual conduct? Yes No
27. Are you aware of any circumstances, incidents, facts, situations, or accidents likely to give rise to a claim, whether valid or not, which might directly or indirectly involve you, your parties, members of your professional corporation, or your employees? .... Yes No

Please provide an explanation for any questions that you responded “yes” to above on a separate page.

AUTHORIZATION/ATTESTATION

I hereby authorize **Carisk Specialty Services, LLC dba Carisk Imaging**, or its designee on behalf of single or multiple Clients to consult and access databases of hospitals, institutions, malpractice carriers, any town, state or federal agency, any health care organization, and/or The National Practitioner Data Bank, in order to verify information contained in my application and interview and authorize **Carisk Specialty Services, LLC dba Carisk Imaging** or its designee to review any of my professional records, civil and criminal records and criminal background. I hereby release and indemnify **Carisk Specialty Services, LLC dba Carisk Imaging**, it's directors, committee members, employees, agents, servants, its subsidiaries and divisions as well as all licensing bodies, hospitals, societies, organizations, state or federal agencies, towns, and associations from all liability resulting from the release of records or information to **Carisk Specialty Services, LLC dba Carisk Imaging**, or its designee for credentialing and verification of the information contained in my application. I hereby agree to allow **Carisk Specialty Services, LLC dba Carisk Imaging**, or its designee to examine my place(s) of business and to survey and evaluate all equipment, appointment availability or patient files used in the provision of health care services. I hereby represent that I will obtain, when necessary the appropriate releases from my patients to permit access to their records so that **Carisk Specialty Services, LLC dba Carisk Imaging**, may conduct medical record review. This patient release does not apply to disclosure of confidential information for purposes other than credentialing and verification of the information contained in my application. Notwithstanding the foregoing, I understand that information relevant to my history, performance and the quality and efficiency of patient care that I deliver, and/or my credentials may be disclosed to other associations and organizations that contract with **Carisk Specialty Services, LLC dba Carisk Imaging**. I hereby agree to notify **Carisk Specialty Services, LLC dba Carisk Imaging**, of any changes in the above information. By my signature, I hereby attest, represent and warrant that all of the information submitted in this provider application is correct, truthful and complete in all respects. I further understand any misstatement, submission of false and/or misleading information or withholding of relevant information may constitute a condition which may not be favorable to my credentialing. I understand and agree that I, as the applicant, have the burden of producing adequate and reliable information for the proper evaluation of my professional competence, character, ethics and other qualifications for resolving any questions about my qualifications. I hereby understand that I shall have the right at my sole cost and expense to review any information gathered by **Carisk Specialty Services, LLC dba Carisk Imaging**, which relates to my behalf. In the event, I believe any of the information to be inaccurate or incorrect, I shall have the right at my expense to contact the source directly and dispute the validity of the information. In the event the source verifies the information to be inaccurate or incorrect, verifying information shall be sent to **Carisk Specialty Services, LLC dba Carisk Imaging**, thereafter **Carisk Specialty Services, LLC dba Carisk Imaging**, at its expense shall correct any information found to be inaccurate or incorrect.

(This application will not be processed if not signed and dated. STAMPED SIGNATURES ARE NOT ACCEPTED.)

Physician's Signature ______________________ Date ______________

Print Name ______________________ Date ______________

Please remember to include copies of the following documents with your completed application.

- Curriculum Vitae
- Board Certificate(s)
- State License(s) to Practice
- DEA and CDS certificate(s) (if applicable)
- Professional liability insurance coverage factsheet (expiration date/policy limits)
- Workers' Compensation Board Authorization Letter (New York State Only)

Please return this form to:

Carisk Specialty Services, LLC
180 Park Ave. Plaza Level, Suite LL103
Florham Park, NJ 07932

Email: providerrelations@cariskpartners.com
Fax: 844-898-6135

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