

ONE CALL MEDICAL INC.

Physician Application

Provider has the right to review information submitted to support credentialing, correct erroneous information, to be informed of application status, upon request, and to be informed of these rights.

Physician Name:	Prof. Suffix: M.D. D.O.	Gender: Male or Female
Name of Center/Facility:		SS#:
Corporate Name:		NPI#:
Street Address:		Date of Birth: (Mo/Day/Yr)
City, State, Zip:		County:
Office Manager/Credentialing Contact:		Telephone #:
E-Mail Address:		Fax #:

2 nd center reading location:	Telephone #:
Street Address:	Fax #:
City, State, Zip:	E-Mail Address:

3rd center reading location:	Telephone #:
Street Address:	Fax #:
City, State, Zip:	E-Mail Address:

4th center reading location:	Telephone #:
Street Address:	Fax #:
City, State, Zip:	E-Mail Address:

How many years of experience do you have interpreting MR films? _____

How many years of experience do you have interpreting CT films? _____

How many years of experience do you have interpreting PET Scans? _____

B Reader Certification

Are you a certified National Institute for Occupational Safety and Health (NIOSH) B Reader?

Yes No

License/Registration

License

List all current licenses and indicate any restrictions or conditions on the license.

Licensed State	License #	Expiration Date	Conditions/ Restrictions (Attach additional sheets if needed)

Controlled Substance Registration

List current federal DEA registrations & state CDS registrations, if applicable.

Certificate	Number	Expiration Date
DEA		
CDS		

Worker's Compensation

Please list your state worker's compensation number, if applicable _____

Physicians in WA, please indicate your DLI number

American Board Certification/Specialties

Specialty: _____ Sub-Specialty: _____

Board	Certified	Date Certified
American Board of Radiology	<input type="checkbox"/> YES <input type="checkbox"/> NO	
American Osteopathic Board of Radiology	<input type="checkbox"/> YES <input type="checkbox"/> NO	
American Board of Nuclear Medicine	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Other Board Certification: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	

If not board certified in Radiology:

- 1) Are you currently board eligible? YES NO
- 2) Have you been accepted by the board to take an exam and are you actively in the board certification process? YES NO
 If yes, indicate the year by which you must complete the process according to the board's requirements _____
- 3) Have you passed the written board exam in Diagnostic Radiology? YES NO
 How many times have you taken the written board exam in Radiology? _____
- 4) If you have passed the written board exam, how many times have you taken the oral exam? _____

Medical Education

Medical School	
Location	
Dates (from/to)	Degree:
ECFMG (Required for graduates of foreign medical schools)	
Certificate #	Date Issued / /

Graduate Medical Training:

Internship

Dates (Mo/Yr) From ___ / ___ To ___ / ___ Type _____

Institution _____

Street Address _____

City / State / Zip _____ Country _____

Residencies

Dates (Mo/Yr) From ___ / ___ To ___ / ___ Specialty _____

Institution _____

Street Address _____

City / State / Zip _____ Country _____

Fellowships

Dates (Mo/Yr) From ___ / ___ To ___ / ___ Specialty _____

Institution _____

Street Address _____

City / State / Zip _____ Country _____

Do you perform TeleRadiology Yes No

If yes, which States do you read for? _____

Professional Liability Insurance

Please list your **current** insurance carrier and any other carrier by which you have been insured within the last **FIVE (5) years**. Please provide the carrier name and policy information as indicated below.

<u>Current Carrier</u>		
Insurance Carrier: _____	Policy Limits: _____	
Address: _____	Policy Number: _____	
Effective Date: _____	Expiration Date: _____	Retroactive Date: _____
<u>Past Carrier(s) to cover history of coverage for the last 5 years</u>		
Insurance Carrier: _____	Policy Limits: _____	
Address: _____	Policy Number: _____	
Effective Date: _____	Expiration Date: _____	Retroactive Date: _____
Insurance Carrier: _____	Policy Limits: _____	
Address: _____	Policy Number: _____	
Effective Date: _____	Expiration Date: _____	Retroactive Date: _____

- Have you ever been denied professional liability insurance? YES NO

- Has your professional liability insurer refused to renew your policy or placed limitations on the scope of your coverage? YES NO

- Have any professional liability insurer expressed an intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage? YES NO

Please provide a full explanation to any questions above to which you responded "yes."

Malpractice Information

- Have you had any malpractice claims brought against you? Yes No
- Have you had any judgments made? Yes No
- Have you had any settlements made? Yes No
- Do you have any claims pending? Yes No

If yes, please provide the following information for each claim. Attach additional sheets if necessary. Please duplicate this form if you were involved in more than one claim.

Date of Occurrence	Name of Carrier		
Provide specific details of the event(s):			
What is (was) your role in the care of the patient(s)?			
What is (was) your status?	<input type="checkbox"/> Primary Defendant	<input type="checkbox"/> Co-Defendant	<input type="checkbox"/> Other
List other defendants:			
Subsequent events, including patient outcome:			
What is the current status of the suit? (If settled, give the amount of the settlement or judgment.)			

Professional Work Experience

Please provide practice history, including month and year, for the past FIVE (5) years. An explanation is required for any gap of six (6) months or longer that appears in your work history. If you completed your professional education and training within the past five (5) years, the work history must cover the time since then.

1. Current Practice _____
Street Address _____
City / State / Zip _____ Country _____
Starting Date _____ Leaving Date _____ Title _____

2. Previous Practice _____
Street Address _____
City / State / Zip _____ Country _____
Starting Date _____ Leaving Date _____ Title _____

Health Status

1. Do you currently have any medical and/or behavioral health problem(s), including illegal substance use, that compromises your ability to perform the essential functions of your profession, with or without accommodation? YES NO

2. Are you currently under the care of a physician for a continuing physical or mental health problem? YES NO

3. Have you been hospitalized or received any other institutional care for a physical or mental health problem in the last five years? YES NO

4. Have you ever been recommended for, or sought treatment for alcohol, controlled or illegal substances dependency or abuse? YES NO

5. Are you currently taking any medications that may affect either your clinical judgment or motor skills? YES NO

Please provide a full explanation to any questions above to which you responded “yes.”

Disciplinary Actions/Sanctions

Please check the appropriate response. If you answer “yes” to any of the following questions, please provide a detailed, signed explanation on a separate sheet of paper.

YES NO

1.	Has your license to practice medicine in any jurisdiction ever been surrendered, denied, suspended, revoked, limited, restricted, or voluntarily relinquished while under investigation?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you ever been reprimanded or placed on probation by a licensing agency?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you ever been formally charged with infractions by the licensing authority of any jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you ever been formally charged with professional misconduct by the licensing authority of any jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Has any federal or state license, registration, or permit to dispense narcotics or other drugs been voluntarily or involuntarily surrendered, denied, revoked, suspended, limited, or restricted?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have your medical staff privileges at any hospital, clinic or other healthcare facility ever been surrendered, denied, suspended, revoked, restricted, or not renewed?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have your medical staff privileges not been renewed by direction of the board of directors at any facility you are affiliated with or employed by?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have disciplinary proceedings ever been instituted against you by a hospital, clinic or other healthcare facility?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been surrendered, denied, suspended, revoked, limited, or restricted?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Has your employment or other relationship with an HMO or other health delivery organization ever been denied, suspended, revoked, limited, or restricted?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Have you ever been charged, or convicted, of any crime related to your clinical practice, including Medicare, Medicaid, or CHAMPUS related crimes?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Have you ever been subjected to civil money penalties under the Medicare, Medicaid, or CHAMPUS program?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Have you been suspended from participating in Medicare, Medicaid, or CHAMPUS?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Have you ever been involuntarily terminated or forced to resign?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Have you ever resigned voluntarily under threat of investigation or threat of sanction?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Have you ever resigned voluntarily from a clinical position with the armed forces or any federal, state or local agency?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Have you ever resigned voluntarily from a clinical position with any other medical employment or practice arrangement?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Have you been sanctioned by a PRO or any federal or state regulatory agency?	<input type="checkbox"/>	<input type="checkbox"/>
19.	Have you ever been convicted of or pleaded no contest to any criminal charges (other than motor vehicle) brought against you?	<input type="checkbox"/>	<input type="checkbox"/>
20.	Have you ever been convicted of or pleaded no contest to a drug or alcohol related offense?	<input type="checkbox"/>	<input type="checkbox"/>

Authorization Release Form

I acknowledge and agree that ONE CALL MEDICAL, INC. has a valid interest in obtaining and verifying information concerning my professional competence, in determining whether to enter into an agreement with me for the provision of medical services. Accordingly,

(I) I represent and warrant to ONE CALL MEDICAL, INC. that the information contained in the foregoing application is correct and complete to the best of my knowledge and belief. I agree to inform ONE CALL MEDICAL, INC. if any material change in such information occurs, whether before or after my entering into an agreement with ONE CALL MEDICAL, INC. for the provision of medical services.

(II) I authorize ONE CALL MEDICAL, INC. to consult with members of medical staffs on hospitals, malpractice carriers and other persons to obtain and verify information concerning my professional competence, character and moral and ethical qualifications, and I release ONE CALL MEDICAL, INC. and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

(III) I consent to the release by any person to ONE CALL MEDICAL, INC. of all information that may be reasonably relevant to an evaluation of my professional competency, character and moral and ethical qualifications including any information relating to any disciplinary action, suspension or curtailment of medical - surgical privileges, and hereby release any such person providing such information from any and all liability for doing so.

(IV) I consent to the release by any person to ONE CALL MEDICAL, INC. of Radiographic films and reports that may be reasonably relevant to an evaluation of my professional competency and/or malpractice claims, settlements, or judgments brought against me.

(V) I attest by signing this application that I have current malpractice coverage.

(VI) I acknowledge that One Call Medical is establishing a limited network of providers and reserves the right to approve or deny my participation in the network. Participation, if granted by OCM, is subject to periodic review.

Physician Name: _____
(Please print or type)

Physician Signature: _____ Date: _____

Occasionally, additional requests may be necessary regarding your credentialing application and may involve requests pertaining to malpractice claims, license sanctions, etc. Would you prefer that we contact you directly for this information or your office manager/Credentialing Contact?

Please note that if neither box is checked, we will always attempt to contact your Office Manager directly.

Contact me (physician) directly

Contact office manager/Credentialing contact

Document must be signed by physician. A signature stamp is not acceptable.