Diagnostic Testing

Your Partner In Diagnostics
ATLANTIC IMAGING GROUP LLC
110 S Jefferson Rd, Suite 201
Whippany, New Jersey 07981

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 #: _____ NY Workers Compensation # (if applicable): _____

UPIN # (if applicable): _____ e-mail address: _____

II. PRIMARY FACILITY INFORMATION

Please list additional Facilities under Section VIII on Page 4

Facility Name: _____ Start Date At Facility: _____ To: Present

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Facility 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

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

Previous Carrier:

Previous Insurance Carrier Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Previous Coverage Limits: _____

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 Occurrence: _____ Date 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 Facility: _____ 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.

_____

_____

_____

_____

_____

_____

_____

_____

_____

IX. CONFIDENTIAL INFORMATION

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 quasi-governmental 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 quasi-governmental 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 professional 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.

X. ATTESTATION & CREDENTIALS VERIFICATION RELEASE

AUTHORIZATION / ATTESTATION

I hereby authorize **MedCheck** Credentialing Services, LLC acting as a credentials verification organization, 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 **MedCheck** Credentialing Services, LLC or its designee to review any of my professional records, civil and criminal records and criminal background. I hereby release and indemnify **MedCheck** Credentialing Services, LLC, 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 **MedCheck** Credentialing Services, LLC, or its designee for credentialing and verification of the information contained in my application. I hereby agree to allow **MedCheck** Credentialing Services, LLC, 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 **MedCheck** Credentialing Services, LLC 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 **MedCheck** Credentialing Services, LLC. I hereby agree to notify **MedCheck** Credentialing Services, LLC, 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 **MedCheck** Credentialing Services, 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 **MedCheck** Credentialing Services, LLC, thereafter **MedCheck** Credentialing Services, LLC, 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	Social Security Number

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 facesheet (expiration date/policy limits)
- ❑ NY Workers' Compensation Board Authorization Letter (if seeing WC patients in New York)

Please return this form to:

MedCheck Credentialing Services, LLC

110 S Jefferson Rd, Suite 201
Whippany, NJ 07981
Fax: 973-451-9541