

# ONE CALL MEDICAL INC. NEURODIAGNOSTIC 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.

**Please list all locations where EMG/NCS is performed - use additional sheets for other locations.**

**Primary Location:**

Physician Name:	Degree:	Gender:	Date of Birth:
Physician's Maiden Name (if any):	NPI#:	Social Security Number:	
Email Address:	Specialty:	Foreign Languages spoken:	
State Worker's Comp Number: <i>In WA, indicate the DLI number:</i>	Minority Owned Business? <i>Circle one: Y / N certificate number, if applicable:</i>	Women Owned Business? <i>Circle one: Y / N certificate number, if applicable</i>	
Partner(s) Name:			
Name of Practice:		Tax ID#:	
Street Address:		Telephone Number:	
City, State, Zip:	County:	Fax Number:	

**Billing Address if different from above office address:**

Billing Company Name (if different from Practice Name): \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Staff Contact List for Above Location**

<b><u>Billing</u></b>	Key Contact Name _____ Phone # _____ Fax # _____	<b><u>Medical Reports</u></b>	Key Contact Name _____ Phone # _____ Fax # _____
<b><u>Scheduling</u></b>	Key Contact Name _____ Central Sched. # _____ Fax # _____	<b><u>Contractual Issues</u></b>	Key Contact Name _____ Phone # _____ Fax # _____

**Second Location:**

Name of Practice:	Tax ID#:
Street Address:	Telephone Number:
City, State, Zip:	County: Fax Number:

**Billing Address if different from above office address:**

Billing Company Name (if different from Practice Name): \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Staff Contact List for Above Location**

<b><u>Billing</u></b>	Key Contact Name _____ Phone # _____ Fax # _____	<b><u>Medical Reports</u></b>	Key Contact Name _____ Phone # _____ Fax # _____
<b><u>Scheduling</u></b>	Key Contact Name _____ Central Sched. # _____ Fax # _____	<b><u>Contractual Issues</u></b>	Key Contact Name _____ Phone # _____ Fax # _____

## 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.

Certificate	Number	Expiration Date
DEA		
CDS		

## BOARD CERTIFICATION

Specialty Board	Certified	Year Certified
American Board of Psychiatry and Neurology	<input type="checkbox"/> YES <input type="checkbox"/> NO	
American Board of Electrodiagnostic Medicine	<input type="checkbox"/> YES <input type="checkbox"/> NO	
ABP&N Specialty Qualification, Clinical Neurophysiology	<input type="checkbox"/> YES <input type="checkbox"/> NO	
American Board of Physical Medicine and Rehabilitation	<input type="checkbox"/> YES <input type="checkbox"/> NO	

1. If not board certified, are you currently board eligible?  
 YES  NO

2. Have you been accepted by the board to take an examination, and are you actively in the board certification examination process?  YES  NO (If Yes: Indicate the year by which you must complete the process according to the board's requirements. \_\_\_\_\_)

## MEDICAL EDUCATION

<b>Medical School:</b> _____	
<b>Location:</b> _____	
<b>Dates (from/to)</b> _____	<b>Degree</b> _____
<b>ECFMG (Required for graduates of foreign medical schools) →IMPORTANT—Please provide hard copy as well.</b>	
<b>Certificate #</b> _____	<b>Date Issued:</b> /     /

**Internship**

Dates (Mo./Yr.) From \_\_\_\_\_ / \_\_\_\_\_ Thru \_\_\_\_\_ / \_\_\_\_\_ Type \_\_\_\_\_  
 Institution \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip \_\_\_\_\_ Program Director \_\_\_\_\_

**Residencies**

Dates (Mo./Yr.) From \_\_\_\_\_ / \_\_\_\_\_ Thru \_\_\_\_\_ / \_\_\_\_\_ Specialty \_\_\_\_\_  
 Institution \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip \_\_\_\_\_ Program Director \_\_\_\_\_

**Fellowships**

Dates (Mo./Yr.) From \_\_\_\_\_ / \_\_\_\_\_ Thru \_\_\_\_\_ / \_\_\_\_\_ Sub-Specialty \_\_\_\_\_  
 Institution \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip \_\_\_\_\_ Program Director \_\_\_\_\_

## POST GRADUATE TRAINING

1. Courses attended and dates


2. Fellowship experience


3. Lectures on Neurodiagnostics given by you, and dates


## HOSPITAL AFFILIATIONS

List your current primary hospital affiliation.

Name \_\_\_\_\_ Affiliated since \_\_\_\_ / \_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Admitting Privileges?     Yes     No    Status:     Active     Courtesy     Consulting

## PROFESSIONAL LIABILITY EXPERIENCE

- |   |  |
|---|--|
| 1. Have you had any malpractice claims brought against you? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you had any judgments made?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you had any settlements made?                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Do you have any claims pending?                          | <input type="checkbox"/> Yes <input type="checkbox"/> 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.)	
What is the amount reserved by your carrier for this claim?	

## 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"/> |

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 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. Has a hospital, clinic or other healthcare facility ever instituted disciplinary proceedings against you?  | <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. 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"/> |
| 12. 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"/> |
| 13. Have you ever been subjected to civil money penalties under the Medicare, Medicaid, or CHAMPUS program?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you been suspended from participating in Medicare, Medicaid, or CHAMPUS?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been involuntarily / terminated or forced to resign?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever resigned voluntarily under threat of investigation or threat of sanction?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. 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"/> |
| 18. Have you ever resigned voluntarily from a clinical position with any other medical employment or practice arrangement?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you been sanctioned by a PRO or any federal or state regulatory agency?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. 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"/> |
| 21. Have you ever been convicted of or pleaded no contest to a drug or alcohol related defense?   | <input type="checkbox"/> | <input type="checkbox"/> |

### 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.

- Current Practice \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip \_\_\_\_\_ Country \_\_\_\_\_  
Starting Date \_\_\_\_\_ Leaving Date \_\_\_\_\_ Title \_\_\_\_\_
- Previous Practice \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip \_\_\_\_\_ Country \_\_\_\_\_  
Starting Date \_\_\_\_\_ Leaving Date \_\_\_\_\_ Title \_\_\_\_\_

### HEALTH STATUS

- 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
- Are you currently under the care of a physician for a continuing physical or mental health problem?  YES  NO
- Have you been hospitalized or received any other institutional care for a physical or mental health problem in the last five years?  YES  NO
- Have you ever been recommended for, or sought treatment for alcohol, controlled or illegal substances dependency or abuse?  YES  NO
- Are you currently taking any medications that may affect either your clinical judgment or motor skills?  YES  NO

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

## 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.

### Current Carrier

Insurance Carrier: \_\_\_\_\_ Policy Limits: \_\_\_\_\_

Address: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Retroactive Date: \_\_\_\_\_

### Past Carrier(s) to cover history of coverage for the last 5 years

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: \_\_\_\_\_

1. Have you ever been denied professional liability insurance?  YES  NO
2. Has your professional liability insurer refused to renew your policy or placed limitations on the scope of your coverage?  YES  NO
3. 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 attach a full explanation to any questions above to which you responded "yes."**

## CREDENTIALS 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 true 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 hospital administrators, 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 be 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, or electromyography and nerve conduction 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 attest by signing this application that I have provided the correct Taxpayer Identification Number \_\_\_\_\_ and Practice Name, \_\_\_\_\_ which are consistent with the information I have filed with the IRS, for all locations listed on this application.

(VII) I attest by signing this application that I will perform all EMG studies personally and that any non-MD professionals performing the Nerve Conduction portion of a study in my office will be supervised in an appropriate manner.

(VIII) 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 in its discretion. If participation is granted, continued participation is subject to periodic review by OCM.

**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**

Physician Name: \_\_\_\_\_

(Please print or type)

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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