PROFESSIONALISM PROGRAM APPLICATION FORM

I. PHYSICIAN PROFILE

A. General Information

Last Name: _____

First Name: _____ Middle Initial: _____

Degree: _____

Specialty: _____

Social Security Number: _____

B. Contact Information

Office Address: _____

City: _____ State: _____ Zip: _____

Office Phone: (_____)_____ Office Fax: (_____)_____

Cellular: (_____)_____ Pager: (_____)_____

Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Home Fax: (_____)_____

Preferred Mailing Address: Office _____ Home _____

Preferred Phone Contact: Office _____ Home _____ Cellular _____ Pager _____

C. Demographic Information

Date of Birth: _____/_____/_____ Country of Birth: _____

Marital Status: Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

Approximate population of city/town where you practice: _____

Approximate population in surrounding area (referral population): _____

Ethnic background **(*optional*):**

African American (not of Hispanic origin) _____

Asian/Pacific Islander _____

Caucasian (not of Hispanic origin) _____

Hispanic _____

Native American/Alaskan Native _____

Other _____ (*please specify*) _____

II. EDUCATION PROFILE

A. Undergraduate Education

Institution/City/State	Degree	Graduation Year

B. Medical School

Institution/City/State	Degree	Graduation Year

C. Post-graduate Training

Internship/City/State	Type	Dates from/to
Residency/City/State	Specialty	Dates from/to
Fellowship/City/State	Specialty/Topic	Dates from/to
Other training/Institution/City/State	Specialty/Topic	Dates from/to

D. Specialty(s)

_____

_____

_____

_____

E. Board Certification(s)

Are you currently ABMS Board Certified?

Yes _____ No _____

Board/Specialty	Certification No.	(Re)Certification Dates
Board/Specialty	Certification No.	(Re)Certification Dates

Does your specialty require recertification?

Yes _____ No _____

If yes, how often? _____

F. Medical Resource Use

1. What medical texts do you have and use in your practice?

_____

_____

_____

_____

_____

2. List the professional journals to which you subscribe and indicate for each whether you usually a) read thoroughly, b) read only selected articles of interest, c) skim, or d) do not read each issue.

Journal	*Usual Use*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

3. How often do you use a medical library or request a literature search?

_____

4. Do you use any on-line or internet-based resources (*i.e. MD Consult*)?

Yes _____ No _____

If yes, what do you use?

_____

_____

_____

_____

_____

III. PROFESSIONAL PRACTICE HISTORY

Give a brief history of where you have practiced since completing your medical training. **(*Please complete this section in addition to attaching your CV*).**

City/State	*Type of Practice*	*Dates from/to*

IV. CURRENT (*MOST RECENT*) PRACTICE PROFILE

A. Practice Affiliation

Nature of Practice: _____

Type of Practice:

Solo _____

Partnership _____ Number of physicians in partnership: _____

Group _____ Number of physicians in group: _____

Other _____ (*please specify*) _____

List types of specialists in group or partnership:

_____

_____

_____

_____

B. Office Staff and Systems

1. List full and part-time office staff titles.
   (*If additional space is required, use back of page or attach extra sheet.*)

Position	***Full or Part-Time***	***Certified/Licensed***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Do you supervise any non-physician health care providers (*PA, nurse practitioner*)?

   Yes _____ No _____

   If yes, how many? _____

   List type of mid-level practitioner(s):

_____ _____

_____ _____

_____ _____

_____ _____

3. Do you maintain the following written manuals and/or protocols?

   Personnel policies and procedures:

   Yes _____ No _____

   Patient care protocols (*instructions, medical information*):

   Yes _____ No _____

   Office policies for patients (*office hours, fees/billing procedures*):

   Yes _____ No _____

4. Do you use computers in your office?

   Yes _____ No _____

5. Do you use a ticker or patient recall system?

   Yes _____ No _____

C. Office Facilities

List equipment available in your office (*e.g. colposcope, endoscopic equipment, ultrasound, treadmill, EKG, X-ray, crash cart, other emergency equipment, etc.)*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

If your office does EKGs or X-rays, do you have system of routine over-reading?

EKGs: Yes _____ No _____

X-rays: Yes _____ No _____

D. Office Procedures

1. What procedures do you routinely perform in your office (*e.g. arthrocentesis, fracture care, skin surgeries, lumbar puncture*):

   _____ _____

   _____ _____

   _____ _____

   _____ _____

2. Check those forms usually included in your office charts:

_____ Summary Problem List

_____ Immunization Sheet

_____ Consultant Reports

_____ Allergy Lists

_____ Medication Lists

_____ Growth and Developmental Charts

_____ Health Maintenance Schedule

3. Do you use a SOAP note format?

Yes _____ No _____

4. Do you initial and date lab reports?

Yes _____ No _____

Do you initial and date X-ray reports?

Yes _____ No _____

Do you initial and date other reports?

Yes _____ No _____

V. PATIENT PROFILE

A. Patient Volume

1. Based on the past twelve months describe:

Average number of days worked per week: _____

Average number of office visits per day: _____

% scheduled: _____ % walk-ins: _____

Average number of hospital admissions per month: _____

Average number of surgical procedures per month:

In-patient: _____ Out-patient: _____

If you provide OB care, list average number of deliveries per month:

Vaginal: _____ C-Section: _____

If C-Section, do you function mainly as:

Primary Surgeon _____ First Assistant _____

Average number of patients in Long Term Care facilities per month: _____

B. Patient Demographics

1. List percent of your patients in each of the following categories:

Gender: Male _____ %

Female _____ %

Age Range:

< 2 _____ %

3 – 18 _____ %

19 – 54 _____ %

55 – 74 _____ %

> 75 _____ %

Payment Mechanism:

Fee for service / private insurance _____ %

Discounted fee for service _____ %

Capitated / Managed Care _____ %

Medicare _____ %

Medicaid _____ %

Indigent / No pay _____ %

2. List the managed health care plans in which you participate:
(*IPA, HMO, PPO, etc.*)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

3. Has a managed care entity or other health insurance carrier cancelled, limited, or not renewed your provider contract?

Yes _____ No _____

If yes, please explain:

_____

_____

_____

VI. HOSPITAL AND LONG TERM CARE (*LTC*) FACILITY PROFILE

A. Primary Hospital Facility

1. Name _____

   Address _____

   Phone (_____)_____

2. Approximate # of beds _____

3. List special units to which you admit (*e.g. detox, rehab*)

   _____

   _____

   _____

   _____

4. Check those services available in which you have privileges at your primary hospital facility:

   _____ Nursery Level: I ____ II____ III____ NA ____

   _____ Lab (24 hr., availability of technician)

   _____ Labor and Delivery Unit

   _____ Radiology

   _____ ICU (# of beds _____)

   _____ Pediatric Unit

   _____ Rehabilitation Unit

   _____ Emergency Room Trauma Level: I ____ II ____ III ____ NA ____

   Staffed By: Full-time ER physician coverage _____

   On-call community physician coverage _____

5. Does the hospital have a medical library?

   Yes _____ No _____

   If yes, does the library have computer literature search capabilities?

   Yes _____ No _____

   Is there a medical librarian?

   Yes _____ No _____

B. Other Hospital Affiliations

Other hospitals at which you are a member of the medical staff.
(*List institution / city / state*)

_____

_____

_____

_____

_____

C. Primary Long Term Care Facility (*LTC*)

Name: _____

Address: _____

Phone: _____

Additional LTC facilities (*List institution / city / state*)

_____

_____

_____

_____

_____

VI. LICENSE AND LIABILITY INFORMATION

A. License

List the states where you are currently licensed to practice medicine and **attach copies of licenses**: Please state for each license whether your license is a) active, no restrictions or stipulations; b) active with restrictions or stipulations; c) inactive; or d) revoked or suspended.

State _____ License # _____ Year _____ Status _____

State _____ License # _____ Year _____ Status _____

State _____ License # _____ Year _____ Status _____

B. DEA Registration

DEA Registration Number: _____

Is your DEA registration current?

Yes _____ No _____

(If yes, attach a copy of your registration.)

C. Malpractice Insurance

Do you currently carry malpractice insurance?

Yes _____ No _____

If yes, Carrier Name _____

Amount of Coverage _____

D. License/Malpractice History

For any questions answered ***yes*****,** provide a brief description, referring to appropriate question number, or allegations, actions and outcomes in the space below. Attach additional page(s) or write on back of page if needed.

1. To your knowledge, have you, or your practice, been subject to investigation by a state licensing board?

   Yes _____ No _____

2. a) Has your medical license been suspended, revoked, or had any limitations or other stipulations placed upon it?

   Yes _____ No _____

   b) Are you currently on probation? If yes, when does the probation period end?

   Yes_____ Date:_____ No____

3. To your knowledge, have you, or your practice, been subject to investigation by a state peer review organization?

   Yes _____ No _____

4. Has an investigation by peer review committees of hospitals, managed care organizations or other institutions led to reductions or restriction of privileges or in any way limited your ability to practice?

   Yes _____ No _____

5. Have you resigned or limited your hospital privileges or in any way limited your ability to practice?

   Yes _____ No _____

6. Have you had any malpractice action(s) filed against you?

   Yes _____ No _____

7. Has your malpractice insurance been revoked, limited or not renewed?

   Yes _____ No _____

8. Has the DEA ever suspended or revoked your license to prescribe controlled substances?

   Yes _____ No _____

Please explain:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PLEASE ATTACH A COPY OF YOUR *ACCUSATION AND DECISION* FROM THE MEDICAL BOARD AND FULL PAYMENT OF $1,995.

PLEASE RETURN TO;

LESLIE IACOPI

IMQ PROFESSIONALISM PROGRAM

180 HOWARD STREET, STE 210

SAN FRANCISCO, CA 94105