

Please include required documents listed on page 2 along with this application.

Name _____ GENDER M F
LAST FIRST MI DATE OF BIRTH

Office Address _____
STREET CITY STATE ZIP

Residence Address _____
STREET CITY STATE ZIP

Phone #s: Office () _____ Home () _____ Fax () _____

Personal Social Security # _____ Billing Tax ID # or SS # _____

State License # _____ DEA Registration # _____

Liability Insurance Company _____ / _____ Full Time Part Time

Ethnic / National Identity _____ I choose not to answer

Podiatry College

Name _____ Year Graduated _____ Degree _____

Post Graduate Education

Type _____ Hospital _____ Year _____
FROM TO

Type _____ Hospital _____ Year _____
FROM TO

Board Certifications

Board _____ Year Certified _____

Board _____ Year Certified _____

Memberships

Organization _____ Office Held _____

Organization _____ Office Held _____

Active Hospital Staff Memberships

Hospital Name _____ City _____

Hospital Name _____ City _____

Do you hold a faculty position? Yes No _____
INSTITUTION RANK

Please list any additional practice locations you may use:

Address _____
STREET CITY STATE ZIP

Have You Had:

- Malpractice actions or pending suits brought against you in the last 7 years Yes No
- Malpractice settlements, judgements or arbitration proceedings? Yes No
- Revocations or suspensions or limitations of hospital practice? Yes No
- Suspensions as a Medicare or Medicaid provider? Yes No
- Professional liability insurance cancellation in the past five years? Yes No
- State licensing investigations or actions? Yes No
- Any conviction of a felony, moral or ethical crime? Yes No
- DEA licensing investigations or actions? Yes No
- Any chronic illnesses, physical defects, or mental health conditions that would impair
your ability to practice your specialty, or have you ever received any treatment for addiction
to drugs or alcohol? Yes No
- More than five percent ownership of any medical facility, joint ownership of medical services
or equipment with a facility to which you might refer patients? Yes No

Have you voluntarily surrendered or limited your:

- License to practice podiatry in any jurisdiction? Yes No
- Staff privileges at any hospital/healthcare institution while under formal or informal
investigation by the institution or a committee thereof? Yes No

Please include an explanation for any question answered yes:

Please submit the following with your completed and signed credentialing form and mail to Podiatry Plan:

1. A copy of your current state license(s).
2. A copy of your DEA Certificate.
3. A copy of your Board Certification(s). If not board certified, when do you plan on taking the exam? Mo. ____ Yr. _____
4. Proof of malpractice coverage (the policy face sheet or certificate of insurance naming Podiatry Plan as certificate holder).
5. A copy of your curriculum vitae or work history.
6. Any and all additional mailing, billing, or office addresses and phone numbers, and additional active
staff hospital affiliations.
7. Any explanations requested elsewhere in this recredentialing form.

All information provided in this or in connection with this application is complete and accurate to the best of my knowledge and I shall immediately notify Podiatry Plan of any changes thereto. I understand that this application does not entitle me to participation in Podiatry Plan. I agree to the acquisition and communication of information pertaining to my qualifications by Podiatry Plan and other persons, including the following: hospitals, medical staffs, schools, professional societies, associations and insurance companies. Additionally, I agree that entities providing information in good faith, pursuant to this release, shall not be liable for any act or omission related to the evaluation or verification of information contained in this application. It is further understood that upon my review as a Podiatry Plan Participating Physician, I shall provide ready access and copies to Podiatry Plan, upon request, of any and all medical records that my office maintains for any Podiatry Plan members.

I hereby agree to the on-going acquisition and communication of information pertaining to my qualifications by Podiatry Plan and other persons, including hospitals, medical staffs, schools, professional societies, associations, and insurance companies as long as I am and agree to remain a Podiatry Plan Provider.

I authorize Podiatry Plan to obtain a copy of my file from the National Provider Data Bank and from any other state or federal agency, hospital, insurer, or professional society or association that maintains a file relating to my professional status or competence, all such files to be held confidential and used solely for the purpose of evaluating the within application, as required by law.

SIGNATURE

DATE

RECEIVED BY PODIATRY PLAN