



PHYSICIAN PRE-APPLICATION

**CENTRAL FLORIDA
PHYSICIANS ALLIANCE, INC.**

*A Physician Owned Independent
Practice Association
Serving Central Florida*

Please Return Completed Pre-Application to:
Ken Emmitt
Central Florida Physicians Alliance
120 E. Pine Street
Suite 11
Lakeland, FL 33801
863.647.0900

Central Florida Physicians Alliance, Inc.

Physician Application Form

Please Type or Print. Fill in All Sections. Incomplete Applications Will Not Be Processed.

To Be Completed by MDs, DOs, DMOs, DDSs, DPMs, ODs, and DCs Date _____

* I _____, hereby certify that I am an independent practicing physician.

I. Demographics

Name (Last, First, Middle)

Home Address/Street

City/State/County/Zip

E-mail Address (Required)

Date of Birth (For Data Bank Query)

Sex: Male _____ Female _____

Do You Have the Legal Right to Work in the US? Y N

Citizenship

SS#

Corporate Name (If different from name above)

II. OFFICE/PRACTICE INFORMATION

Please Include All Office/Practices, Using Attached Additional Sheets if Necessary

Participation Status For Which You are Applying: (Indicate Specialty)

Primary Care Specialty Care: Specialty _____ Subspecialty: _____

Primary Office Address/Street

City/State/Zip

Website address

Office Phone

Office Fax

Office Manager

Federal Tax ID#

Billing Address/Street (If Different from Above)

Billing City/State/Zip

* If you are not an Independent Practicing Physician you are ineligible to join. Misinformation or misrepresentation of your practice status will be grounds for termination. _____ Initials

Type of Practice: (Circle One) Solo Single Specialty Group Multispecialty Group Other

If Group Practice, Please List Other Members of Your Practice, Their Specialties & Coverage Arrangements

Accept New Patients from Physician Referral Only? Y N
 Accept Medicare Assignment? Y N
 Accept Medicaid Assignment? Y N
 State _____

III. A MEDICAL EDUCATION

(List All Medical Education, Attaching Additional Sheets If Necessary)

Medical/Professional School Name

Address/Street

City/State/Zip/County

Dates Attended (From – To)

Degree Awarded

(Attach Additional Sheets if Necessary)

III. B POSTGRADUATE TRAINING INTERNSHIP

Institution Name

Address/Street

City/State/Zip

Dates Attended (From - To)

Program Director

Type of Internship

III. C POSTGRADUATE TRAINING RESIDENCY/FELLOWSHIP(S)

(Attach Additional Sheets If Necessary)

Institution Name

Address/Street

City/State/Zip

Dates Attended (From - To)

Program Director

Type of Residency/Fellowship

IV. A HOSPITAL AFFILIATIONS

Current Primary Hospital Name

Address/Street

City/State/Zip

Status of Privileges Key

- | | | | |
|-------------------------------|--------------|-----------------|-----------------|
| 1. Active | 5. Visiting | 9. Senior Staff | 13. Pending |
| 2. Courtesy Provisional Staff | 6. Temporary | 10. Provisional | 14. Other _____ |
| 3. Active Provisional Staff | 7. Courtesy | 11. Suspended | |
| 4. Associate | 8. Admitting | 12. Consulting | |

Status of Privileges (Indicate by Using Key)

Any Past or Present Restrictions of Privileges Y N (If Yes, Explain)

Date of Employment

LIST ALL HOSPITALS AT WHICH YOU HAVE OR HAVE HAD PRIVILEGES (Attach Additional Pages if Needed)

Hospital Name

Address/Street

City/State/Zip

Status of Privileges (Indicate by Using Key)

Dates of Employment

Any Past or Present Restriction of Privileges

Y N (If Yes, Explain)

Hospital Name

Address/Street

City/State/Zip

Status of Privileges (Indicate by Using Key)

Dates of Employment

Any Past or Present Restriction of Privileges

Y N (If Yes, Explain)

Hospital Name

Address/Street

City/State/Zip

Status of Privileges (Indicate by Using Key)

Dates of Employment

Any Past or Present Restriction of Privileges

Y N (If Yes, Explain)

VI. PRACTICE SPECIALTY

Primary Specialty

National Board Certification

Certification Number

Name of Board

Date of Certification

Expiration Date

Date of Recertification

If Intending to Sit for Boards, Specify Date

Secondary Specialty

Board Certification

Certification Number

Name of Board

Date of Certification

Expiration Date

Date of Recertification

If Intending to Sit for Boards, Specify Date

VII. WORK HISTORY

(List All Positions Since Medical School, Attaching Additional Sheets if Necessary)

Name of Current Practice

Contact Name

Address/Street

City/State/Zip

Phone

Fax

Dates of Employment (From - To)

Name of Previous Practice/Employer

Contact Name

Address/Street

City/State/Zip

Phone

Fax

Dates of Employment (From - To)

Name of Previous Practice/Employer

Contact Name

Address/Street

City/State/Zip

Phone

Fax

Dates of Employment (From - To)

VIII. PROFESSIONAL CERTIFICATES/LICENSES/NUMBERS

State License Number/State of License

Expiration Date

Other State License Number/State of License

Expiration Date

Federal DEA Number/State of License

Expiration Date

UPIN Number

Expiration Date

State Medicare Number/State of License

Expiration Date

State Medicaid Number

Expiration Date

VII. PROFESSIONAL CERTIFICATES/LICENSES/NUMBERS CONT.

 CDS Certification

 ECFMG Number

IX. PROFESSIONAL LIABILITY INSURANCE

 Current Carrier Name

 Address/Street

 City/State/Zip

 Dates of Coverage

 Policy Number

 Coverage Amount Per Occurrence/Aggregate

 Policy Type

 Occurrence's)

 Claim(s) Paid

 Length of Time with Current Carrier

ALL PREVIOUS CARRIER(s) (Attach Additional Sheets if Necessary)

 Name(s)

 Dates Covered (From - To)

X. MALPRACTICE CLAIMS HISTORY

(Provide Information for All Cases Occurring in Previous 10 Years. Attach Additional Sheets if Necessary)

 Date of Occurrence

 Date Claim was Filed

 Professional Liability Carrier Involved

 Name of Patient

 Name of Plaintiff if Other than Patient

You were: Primary Defendant Co-Defendant (Circle One)

IX. MALPRACTICE CLAIMS HISTORY CONT.

Other Defendants (If Any)

Describe the Allegations Against You

Describe the Alleged Injury to the Patient

Claimant/Plaintiff Filed Suite in Court (Circle One) Y N

State Court Case Number

State

County/Parish

Federal Court (US District Court) Case Number

District

Present Status of the Claim/Case (Include Amount Awarded/Attributed/of Settlement)

- | | | | |
|------------------------------------|--------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Pending | <input type="checkbox"/> Settled | <input type="checkbox"/> Arbitrated | <input type="checkbox"/> Award Amount _____ |
| <input type="checkbox"/> In Appeal | <input type="checkbox"/> Adjudicated | <input type="checkbox"/> "Other | <input type="checkbox"/> Amount Being Sought _____ |

Additional Information/Explanation

(Please Provide an Explanation for any "Yes" Responses on a Separate Page)

XI. ADDITIONAL QUESTIONS

- | | | |
|---|---|---|
| 1. Have any of your board certifications ever been suspended, revoked, or voluntarily surrendered? | Y | N |
| 2. Have you ever been named as a defendant in any criminal case? | Y | N |
| 3. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified? | Y | N |
| 4. Has your malpractice insurance ever been canceled, suspended, not renewed, restricted, or special-rated-rated? | Y | N |
| 5. Has your license to practice medicine in any state been suspended, restricted, revoked voluntarily surrendered, being subject to a consent order, or has probation ever been evoked? | Y | N |
| 6. Has your federal or state controlled substance license ever been suspended, revoked, or voluntarily surrendered, reduced, or restricted, or not renewed, or has probation ever been invoked? | Y | N |
| 7. Have your privileges at any hospital or other health care setting ever been suspended, revoked, voluntarily surrendered, reduced, or restricted, or not renewed, or has probation ever been invoked? | Y | N |

XI. Additional Questions Cont.

- | | | |
|---|---|---|
| 8. Within the last five years, have you ever been a participating provider of another HMO, PPO, PHO, or MSO, etc. with which you are not affiliated at this time? | Y | N |
| 9. Have you ever received sanctions from a regulatory agency (e.g. CLIA, OSHA, Etc)? | Y | N |
| 10. Has any information on you ever been reported to the National Practitioner Date Bank? | Y | N |
| 11. Are you currently engaged in the illegal use of drugs? (Illegal use of drugs means the use of controlled substances obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day or even the weeks preceding the completion of this application. Rather, it means recently enough so that that the illegal use may have an impact on one's ability to practice) | Y | N |
| 12. Is your physical or mental health such that it may impair your ability to practice within the scope of privileges for which you have applied, with or without reasonable accommodation? | Y | N |
| 13. Within the last five years, have you ever been reprimanded or disciplined in any manner by any state licensing authority or other professional board or peer review committee for conduct related to the use of alcohol or the use of any drug? | Y | N |
| 14. Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic testing center, hospital, ambulatory surgery center, or other business dealing with the provision of ancillary health services, equipment, or supplies? If so, please provide the following information? | Y | N |

Name of Organization

Type of Organization

Address/Street

City/State/Zip

Telephone Number

Tax Identification Number

XII. PROFESSIONAL REFERENCES

Name

Phone

Address/Street

City/State/Zip

Name

Phone

Address/Street

City/State/Zip

Name

Phone

Address/Street

The credentials information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information I have provided and the responses I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I understand that this application does not entitle me to participation in the network of any health plan using the application. I agree that any health plans using this application, their representatives, and any individuals or entities providing information to such health plans in good faith shall not be liable for any act or omission related to the evaluation or verification contained in this application. I further agree to notify Central Florida Physicians Alliance with which I participate, and which uses this application, about any change to the information provided in this application within 30 days of any such change. Information requested in this application that is not publicly available will be treated as confidential by health plans using it. My signature here authorizes verification on the information I have provided.

Applicant Signature

Print Name

Print Degree

Date

ADDITIONAL DOCUMENTATION

(Please Attach Copies of the Following Documents If Applicable)

- √ Current State Drivers License/ID
- √ Current State License
- √ State Controlled Dangerous Substance Certificate
- √ Current Federal DEA Registration
- √ ECFMG Certificate
- √ Board Certification Certificate
- √ Medical School Diploma (MD/DO)
- √ Internship certificate
- √ Residency certificate
- √ Current Professional Liability Insurance Face Sheet
- √ Current CV/Resume
- √ W-9
- √ CMS-1500 (boxes 25, 31, 32, & 33 filled out)
- √ NPI
- √ **How were you referred to the CFPA?** _____

Please Photocopy if Necessary, and Provide Information for Every Additional Office Location

Additional Office Address/Street

Office Phone

Fax

Office Manager

Federal Tax ID#

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Languages Spoken by Physician or Staff (Other than English)

M.D. _____

Staff _____

Are Interpreters Available Y N

After Hours Telephone Numbers
Does Your Office: (Circle One)

Make 24 hour Phone Coverage Available Y N Employ Allied Health Professionals? Y N

Have Capability for Electronic Billing? Y N Meet ADA Accessibility Standards? Y N

Have Public Transportation Accessibility? Y N

Type of Practice: (Circle One) Solo Single Specialty Group Multispecialty Group Other

If Group Practice, Please List Other Members of Your Practice, Their Specialties, and Coverage Arrangements
Do You Currently: (Circle One)

Accept New Patients into Your Practice? Y N Accept New Patients from Physician Y N

Have Medicare Certification? Y N Referral Only?

Provide Inpatient Care? Y N Accept Medicare Assignment? Y N

Accept Medicaid Assignment? Y N

State _____

<p>Please submit completed application to: Central Florida Physicians Alliance 120 E. Pine Street Suite 11 Lakeland, Florida 33801 Telephone (863) 647-0900 * Fax (863) 647-0966</p>
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CENTRAL FLORIDA PHYSICIANS ALLIANCE Consent and Release Form

I hereby give permission to the Central Florida Physicians Alliance, [hereafter referenced as CFPA] and any managed care plan or insurance plan with which the CFPA contracts, permission to request information regarding my professional credentials and qualifications from education facilities, the chief[s] of the clinical department[s] of the hospital[s] in which I currently have or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers including the Federation of State Medical Boards and the National Practitioner Data Bank.

The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter applicable to the credentialing process.

I authorize the educational facilities, the chief[s] of the clinical department[s] of the hospital[s] in which I currently have or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers to submit information directly requested by the CFPA or Plans with which the CFPA is contracted including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and lawsuit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing process. I further release and agree to hold harmless all entities, their representatives, employees, and agents, including the Federation of State Medical Boards and the National Practitioner Data Bank, from any and all liability for any damages that may result from providing this information as long as such release of information is done in good faith and without malice.

I agree that a photocopy or facsimile of this document with my signature may be accepted by any person or entity from which such information is sought with the same authority as the original for two years from the date on this form and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request.

I understand that a condition of this reappointment process is that any misrepresentation, misstatement or omission from the Reappointment Form, whether intentional or not, is a cause for automatic and immediate rejection of my reappointment application by the CFPA and any Plans and may result in denial of my reappointment or termination of my participation in Plan[s]. I further understand that any misrepresentation, misstatement or omission from this application, if discovered after network participation has been awarded to me, may lead to immediate suspension or termination of network privileges. I agree to use my best efforts to inform the CFPA within 15 working days of any change in the information provided or in the answers to questions on the Reappointment Application as a result of developments subsequent to my signing this Consent and Release Form. I understand that I will receive written notice of my reappointment to the CFPA.

I warrant that I have the authority to sign this Consent and Release Form, on my behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I agree that submission of this form does not constitute approval or acceptance as a participating provider in any Plans with which the CFPA contracts.

If I am accepted for Reappointment to the CFPA and Plan participation, I consent to the inspection of my patient records as necessary for peer and utilization review purposes by representatives of the CFPA or Plans subject to proper confidentiality restrictions and authorization and agree to be bound by the CFPA agreement and/or participation agreement.

I understand that if my Reappointment Application is rejected for reasons relating to my professional conduct or competence, the CFPA and/or any Plan may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank.

I understand that I have the right to review and correct erroneous information obtained by the CFPA and any Plan to evaluate my credentialing application. This does not require the CFPA or any Plan to allow me to review references or recommendations or other information that is peer review protected.

NOTE: Your signature is required to complete this form. Stamped signatures are not acceptable.

NAME (Please print or type)

Signature

Date