Date: _____

Medical Provider Application

Last:_____ First:_____ Middle Initial:_____

Professional Designation: M.D. ☐ D.O. ☐ N.P. ☐ P.A. ☐

Date of Birth: _____ Soc. Sec #:_____

NPI #:_____ State and Country of Birth: _____

If you require payment to a corporation name, please list name and Tax ID number:

Name: _____ Tax ID #: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Cell: _____

Office Telephone: _____ Fax: _____

Email: _____

***We typically contact physicians primarily by email. Please make sure to supply us with a correct email that you can check often.**

Education/Experience

Name of Medical School: _____

Date of Graduation: _____

Address of School: _____

Primary Specialty: _____

Licenses and Certificates

Medical License

1. _____ ST: _____ EXP: _____
2. _____ ST: _____ EXP: _____
3. _____ ST: _____ EXP: _____
4. _____ ST: _____ EXP: _____

DEA#: _____ EXP: _____

Check those that apply: ACLS: ☐ PALS: ☐ BLS: ☐ ATLS: ☐

Are you board certified? Yes ☐ No ☐ If yes, which board: _____

If you have already registered with CAQH and received login information, please provide below:

CAQH ID number: _____

User Name: _____ Password: _____

File Release

I hereby release from liability all representatives of ERx, LLC, the hospital, and its medical staff for their acts in good faith and without malice in connection with evaluating my application, my credentials and my qualification. I also hereby release from any liability any individuals and organizations that provide information to ERx, LLC, the hospital, and its medical staff, in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

_____

Physician's Signature

If the answer to any of the following is "Yes" please give full details on a separate sheet:

1. Has your medical license in any state ever been limited, denied, suspended or revoked?
   Yes ☐ No ☐
2. Have you ever voluntarily surrendered any license to practice medicine?
   Yes ☐ No ☐
3. Have your privileges at any hospital ever been suspended, diminished or revoked?
   Yes ☐ No ☐
4. Have you ever been denied membership or renewal thereof or been subject to disciplinary action by any medical organization?
   Yes ☐ No ☐
5. Have any professional liability claims or suits been made against you in the last 10 years?
   Yes ☐ No ☐
   If yes, how many_____ If pending, how many _____
6. Have any judgments or settlements been made against you in professional liability cases within the last ten years?
   Yes ☐ No ☐
7. Has your professional liability insurance ever been denied, cancelled or refused renewal?
   Yes ☐ No ☐
8. Has your DEA certificate ever been denied, suspended, revoked or limited?
   Yes ☐ No ☐
9. Have you ever been convicted of a crime other than a minor traffic violation?
   Yes ☐ No ☐
10. Are you, or have you ever abused or been addicted to alcohol, narcotics or other drugs?
    Yes ☐ No ☐
11. Do you currently have any chronic illness or physical defect that would interfere with work duties?
    Yes ☐ No ☐
12. Have you ever been treated for an emotional/mental illness, sexual addiction, anger management or similar illnesses?
    Yes ☐ No ☐
13. Has an allegation or claim of sexual misconduct been made against you?
    Yes ☐ No ☐

Please check those that apply:
I am familiar with the legal requirements in the state where I will be practicing relating to:

☐ Patient leaving against medical advice
☐ Child abuse
☐ Rape
☐ Suicide attempt
☐ COBRA/EMTALA
☐ Restraint training
☐ Commitment procedures/voluntary & involuntary
☐ Acute alcohol intoxication
☐ Patient in custody
☐ Coroner's cases
☐ J.C.A.H.O. emergency dept. regulations

Providers Signature:_____ Date_____