

Healthcare Professionals Application (PLEASE PRINT OR TYPE)

GENERAL INFORMATION

| | |
|----------------------------|--|
| NAME (LAST, FIRST, MIDDLE) | |
| DATE OF BIRTH | |
| MAILING ADDRESS | |
| TELEPHONE | E-MAIL ADDRESS |
| REQUESTED SPECIALTY | LIST LANGUAGES SPOKEN OTHER THAN ENGLISH |

PRIMARY LOCATION (PLEASE ATTACH ADDITIONAL SHEET FOR OTHER LOCATIONS)

| | |
|---|----------------|
| GROUP PRACTICE NAME (IF APPLICABLE) | |
| MAILING ADDRESS (PLEASE INCLUDE COUNTY) | |
| TELEPHONE | E-MAIL ADDRESS |

LICENSE

| STATE/COUNTRY | LICENSE NUMBER | EXPIRATION DATE |
|--|----------------|-----------------|
| DO YOU HAVE A LICENSE IN ANY OTHER STATES OR COUNTRIES? IF YES, PLEASE LIST. | | |
| STATE/COUNTRY | LICENSE NUMBER | EXPIRATION DATE |
| STATE/COUNTRY | LICENSE NUMBER | EXPIRATION DATE |

AFFIRMATION AND RELEASE

I hereby authorize and consent to the release of information by any hospital or hospital’s medical staff, medical associations, National Practitioner Data Bank, other government agencies, malpractice insurance carriers, and previous and present and other interested parties regarding information concerning me. I hereby release the plan, its staff, as well as the institution(s) or organizations providing such information and their staff, from any and all liability for the obtaining and release of such information. I also understand that I have a continuing obligation to amend and update my answers.

By my signature, I hereby attest that the information in this application is complete and accurate and I agree to provide information as required to support this application. The undersigned hereby certifies that the above information requested is truthful, correct and complete in all respects. The undersigned further understands that the submission of false and/or significantly misleading information or the withholding of relevant information is grounds for termination of the contact.

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|---------------------|------|
| APPLICANT SIGNATURE | DATE |
|---------------------|------|

