

APPLICATION DESERT VALLEY INDEPENDENT PHYSICIAN

A current copy of your CV with dates in MM/YYYY format, CA Medical License, DEA License, facesheet of Medical Malpractice Liability insurance, current government issued photo ID, passport picture and a \$500.00 check made out to DVIP, must accompany this application.

I. IDENTIFYING INFORMATION

Last Name	Maiden / Other Name(s)	First Name	Initial
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Residence Address	City	State	Zip Code	E-mail Address
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Home Telephone Number	Cell Phone Number	Social Security Number
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Date of Birth	Place of Birth	Citizenship	Visa Status
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NPI Number: _____

II. GENERAL PROFESSIONAL INFORMATION

Specialty/Subspecialty _____

Associates/Partners _____

New Practice/Group Name _____

Office Address	City	State	Zip Code	Telephone	Fax
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IV. HEALTH INFORMATION

I hereby affirm that I am physically and mentally able to carry out the responsibilities of medical staff membership and exercise the privileges requested.

Yes _____

No _____

VI. MEDICAL EDUCATION

Medical School	Degree	Date of Graduation
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Address	Telephone	Fax Number
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VIII. POST GRADUATE EDUCATION / FELLOWSHIPS

Program	Address	Telephone/Fax Number	Dates (Month/Year)
Completed satisfactorily? ____ Yes ____ No			

Program Completed satisfactorily? ____ Yes ____ No	Address	Telephone/Fax Number	Dates (Month/Year)
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Program Completed satisfactorily? ____ Yes ____ No	Address	Telephone/Fax Number	Dates (Month/Year)
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Does this represent an approved program, of sufficient duration, to fulfil that portion of the requirements to take boards in your specialty? (circle) Yes No

IX. BOARD CERTIFICATION AND RECERTIFICATION

1. Certified by: _____ Date: _____

Certificate Number: _____ Date: _____

Last Recertification: _____ Date: _____

2. Certified by: _____ Date: _____

Certificate Number: _____ Date: _____

Last Recertification: _____ Date: _____

X. LICENSES HELD

Circle appropriate degree: MD DO DDS DPM Other _____

Current California medical or dental licenses

License Number	Degree
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Drug Enforcement Admin. (DEA) Registration Number _____

XI. HOSPITAL AFFILIATIONS (all past and present)

List in chronological order; do NOT include residency.

Hospital	Address	Email	Telephone/Fax Number	Dates (Month/Year)
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Hospital	Address	Email	Telephone/Fax Number	Dates (Month/Year)
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Hospital	Address	Email	Telephone/Fax Number	Dates (Month/Year)
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Hospital	Address	Email	Telephone/Fax Number	Dates (Month/Year)
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XII. PROFESSIONAL LIABILITY INSURANCE INFORMATION

Current Insurance Carrier Agent (if any)	Policy Number	Expiration Date
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Policy Limits

Address

Telephone

Fax Number

XIV. PROFESSIONAL REFERENCES

Please submit the names of three individuals who have had direct clinical observation or other work with you. List below the names, addresses, relationships and the dates of association with each. You must include your current or most recent supervisor.

1. _____
Name Relationship Dates

Address

Telephone Fax Number Email Address

2. _____
Name Relationship Dates

Address

Telephone Fax Number Email Address

3. _____
Name Relationship Dates

Address

Telephone Fax Number Email Address

XVI. MISCELLANEOUS INFORMATION:

Are you now or have you EVER been subject to: (provide FULL details for positive answers on a separate sheet.) Please place a check mark on each line.

	YES	NO
1. Previously successful or currently pending limitation, suspension, revocation, voluntary or involuntary surrender of license or registration to practice in any jurisdiction?	_____	_____
2. Previously successful or currently pending limitation, suspension, revocation, voluntary or involuntary surrender of Drug Enforcement Administration (DEA) registration?	_____	_____
3. Limitation, suspension, probation, revocation, denial, non-renewal, voluntary or involuntary surrender of employment, appointment, privileges or training at any hospital or health care related institution?	_____	_____
4. Withdrawal of your application for appointment, reappointment, or clinical privileges or resignation from a medical staff <u>before</u> a potentially adverse decision was made by a hospital's or health care facility's governing board?	_____	_____
5. Formal investigation, corrective action, or discipline by any hospital or health care related institution for any reason, including patient complaints?	_____	_____
6. Pending professional malpractice claims or actions, medical conduct proceedings or licensing board actions in any jurisdiction?	_____	_____
7. Any judgment, settlement, or findings of medical malpractice or any findings of professional misconduct in any jurisdiction.	_____	_____
8. Suspension, sanction or other restriction in participation in any private, Federal or State insurance program (e.g. Medicare)?	_____	_____
9. Current police or agency investigation, substantiated charges or convictions for sexual harassment, sexual abuse, child abuse, elder abuse, findings pertinent to violations of patient's rights, or other human rights violations?	_____	_____
10. Criminal convictions, pending criminal proceedings, or arrests for felonies or misdemeanors?	_____	_____
11. Malpractice premium "rating", surcharge, malpractice insurance cancellation, denial or non-renewal?	_____	_____
12. Resignation, withdrawal or termination of your position with a professional association or health maintenance organization for reasons related to clinical, quality or patient care issues?	_____	_____
13. Do you currently have any physical or mental condition that impairs or could impair your ability to practice medicine?	_____	_____
14. Do you currently habitually use drugs or alcohol, or have a dependence on drugs or alcohol (or have you ever had such habitual use of or dependence on drugs or alcohol) that impairs or could impair your ability to practice medicine?	_____	_____

XVII. AFFIRMATION OF INFORMATION

The undersigned hereby affirms under the penalties of perjury as follows: that he/she is the applicant named herein; that he/she has read the foregoing application and knows the contents thereof; that the same is complete, true and accurate to his/her own knowledge and belief.

I have read The Upstate Pledge: A Code of Conduct and Mutual Respect. By submitting my application, I agree to adhere to acceptable conduct as outlined by the By-laws, and abide by all requirements of behavior and civility therein.

Signature _____ Date _____