

PRINT NAME: _____

QUESTIONS #15, 20 & 21 – Disciplinary actions

Attach additional pages with same format where more than one action was taken or is pending, and where otherwise necessary.

Name of agency or institution taking action: _____ Date: ____/____/____

Description: _____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence related to the disciplinary action directly to the Board.

QUESTIONS #14, 16-A, 16-B, 16-C &17 – Medical school and postgraduate training program

Attach additional pages with same format where necessary.

Name of institution: _____ Date of action: ____/____/____

Address: _____ City: _____

State: _____ Zip: _____ Dates of attendance: From: ____/____/____ To: ____/____/____

Description of events: _____

You must arrange for the appropriate agency or institution to submit all official documentation and correspondence regarding any probation, termination, leave of absence, withdrawal, failure to complete or requirement to repeat directly to the Board.

QUESTIONS #18 & 19 – License application withdrawal, denial or license surrender

Attach additional pages with same format where necessary.

Describe circumstances under which license application was withdrawn or denied, or license was voluntarily surrendered.

State: _____ Year: ____/____/____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding the withdrawal, denial or voluntary surrender directly to the Board. Such documentation must specify the reason(s) for denial or withdrawal of your license application or voluntary surrender of your license application.

Signature: _____

Date: ____/____/____

PRINT NAME: _____

QUESTIONS #22, 23, 24 & 25 – Medical staff membership, status and/or privileges

Attach additional pages with same format where necessary. Describe circumstances leading to change in medical staff membership, status and privileges:

Name of facility: _____ Date of action : ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Description: _____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding any affirmative responses to Questions 22, 23, 24 and 25 directly the Board.

QUESTION #26 – Criminal proceedings

Attach additional pages with same format if more than one charge and where otherwise necessary.

Court: _____ Charge: _____ Date: ____/____/____

Please attach a detailed account of circumstances leading up to criminal proceedings.

Status: _____

You must arrange for your lawyer or the court officer to submit copies of the police report, indictment, complaint and judgment or other disposition in any criminal proceedings in which you were a defendant directly to the Board.

QUESTION #27 – Controlled substances privileges

Attach additional pages with same format where necessary.

Type of restriction: _____ Date: ____/____/____

Circumstances of restriction: _____

You must arrange for the appropriate agency or institution to submit a copy of all official orders, findings of fact and correspondence related to any affirmative response directly to the Board.

Signature: _____ Date: ____/____/____

PRINT NAME: _____

QUESTIONS #28 & 29 – Malpractice claims and other lawsuits

You must provide the following information on this form for each instance of alleged malpractice. You may photocopy this form and attach additional copies, if necessary. You must also complete the back of this form. Please print legibly.

Claimant’s name: _____ Date of incident: ___/___/___

Insurer’s name: _____ Insurer’s address: _____

Description of alleged basis (es) of claim (allegations only: this does not constitute an admission of fault or liability). (See Basis for Allegation on page 7.)

Allegation _____ Allegation _____ Allegation _____

REQUISITE DESCRIPTIVE INFORMATION:

1. Patient’s condition at point of your involvement: _____

2. Patient’s condition at end of treatment: _____

3. The nature and extent of your involvement with the patient: _____

4. Your degree of responsibility for the course of treatment leading to the claim: _____

5. If incident resulted in patient’s death, indicate cause of death according to autopsy or patient chart: _____

Incident location (check one):

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> 01 Emergency Room | <input type="checkbox"/> 02 Labor/Delivery | <input type="checkbox"/> 03 Laboratory/X-ray/Testing | <input type="checkbox"/> 04 Operating Room |
| <input type="checkbox"/> 05 Outpatient | <input type="checkbox"/> 06 Patient Room | <input type="checkbox"/> 07 Hospital-Other | <input type="checkbox"/> 08 Hospital-Unknown |
| <input type="checkbox"/> 09 HMO | <input type="checkbox"/> 10 Clinic | <input type="checkbox"/> 11 Nursing Home | <input type="checkbox"/> 12 Physician’s Office |
| <input type="checkbox"/> 13 Walk-in Center | <input type="checkbox"/> 14 Other | <input type="checkbox"/> 15 Unknown | |

Your role (check one):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> 01 Anesthesiologist | <input type="checkbox"/> 02 Primary Care Physician | <input type="checkbox"/> 03 Referring Physician | <input type="checkbox"/> 04 Attending Physician |
| <input type="checkbox"/> 05 Consultant Specialist | <input type="checkbox"/> 06 Surgeon | <input type="checkbox"/> 07 Fellow | <input type="checkbox"/> 08 PGY 7 |
| <input type="checkbox"/> 09 PGY 6 | <input type="checkbox"/> 10 PGY 5 | <input type="checkbox"/> 11 PGY 4 | <input type="checkbox"/> 12 PGY 3 |
| <input type="checkbox"/> 13 PGY 2 | <input type="checkbox"/> 14 PGY 1 | <input type="checkbox"/> 22 Acupuncturist | <input type="checkbox"/> 26 On-call Physician |
| <input type="checkbox"/> 27 Worker’s Comp
Evaluator | <input type="checkbox"/> 28 Court Psychiatrist | <input type="checkbox"/> 24 Group Practitioner/Partner | <input type="checkbox"/> 99 Unknown |
| | <input type="checkbox"/> 98 Other | | |

PRINT NAME: _____

QUESTION #28 & 29 - Malpractice claims & other lawsuits, continued...

Legal representative's name: _____

Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____

Current status of claim: Closed PendingWas the case resolved before the entry of a verdict? Yes NoWhat was the decision? Dismissed before trial Plaintiff Verdict Defense VerdictDecision determined by: Judge JuryIf a payment was made: Amount allocated to you: \$ _____ Payment Date: ____/____/____

In addition to the information listed above, you must arrange for your lawyer or liability carrier to submit a copy of the following documents directly to the Board for the following malpractice cases:

Open case – a copy of the complaint naming the physician as a defendant.

Closed case – a copy of the complaint and final judgment, settlement and release or other final disposition of each claim, even if you were dismissed from the case by the court and/or if the case was closed with or without prejudice and the amount of monies paid on your behalf.

Dismissed case – a copy of the dismissal if you were dismissed before the case was reviewed by a tribunal or jury. The dismissal must include the name or initials of the patient and confirmation that no monies were paid on your behalf.

NOTE: Please be advised that the Board may request pertinent medical records or additional information.

Signature: _____ Date: ____/____/____

PRINT NAME: _____

CONFIDENTIAL MEDICAL INFORMATION

QUESTION #30 & 31 – Medical condition

If you answered “yes” to Questions #30 or 31, please set forth the specifics of your condition and any related treatment, including dates and diagnoses. In addition, set forth any adjustments or interventions you may have made or taken to ameliorate or address the impact of your medical condition on your current practice, including a change of specialty or field of practice, or participation in any supervised rehabilitation program, professional assistance or retraining program, or monitoring program. You must arrange for your physician to send directly to the Board an evaluation of your current medical status, noting diagnosis, prognosis, treatment plan, and impact of condition on ability to practice medicine. This evaluation must be performed no more than three (3) months prior to the date of your application. At a later date, you may be asked to submit additional information, including documentation of compliance with any monitoring program.

QUESTION #32 – Use of chemical substances

If you have obtained medical treatment related to your use of chemical substances, set forth the specifics of your treatment, including dates and diagnoses. In addition, set forth any adjustments or interventions you may have made or taken to ameliorate or address the impact of your use of chemical substances on your current practice, including participation in any supervised rehabilitation program or monitoring program. You must arrange for your physician to send directly to the Board an evaluation of your current medical status, noting diagnosis, prognosis, treatment plan, and impact of condition on ability to practice medicine. This evaluation must be performed no more than thirty (30) days prior to the date of your application. You must also arrange for the appropriate institutions to submit all discharge summaries regarding any alcohol or drug dependency directly to the Board. At a later date, you may be asked to submit additional information, including documentation of compliance with any monitoring program.

Signature: _____

Date: ____/____/____

PRINT NAME: _____

QUESTION #33 – Refusal to take screening test

If you answered “yes” to Question #33, please set forth a description of the circumstances leading to the refusal to take the screening test and any resulting criminal or disciplinary consequences.

QUESTION #34 – Illegal use or misuse of drugs

List chemical substances:

Describe frequency of usage: _____

Please note that additional information may be requested by the Board.

QUESTION #35 – Voluntary modification of scope of practice

Describe circumstances leading to modification of practice: _____

Describe modification of practice: _____

Dates: From: ____/____/____ To: ____/____/____

Please note that additional information may be requested by the Board.

Signature: _____

Date: ____/____/____

BASIS FOR ALLEGATION**ABUSE OF (PATIENTS,
EMPLOYEE(S)/PEER(S)**

Abuse of Employee(s)/Peer(s) - Physical
Abuse of Patient(s) - Physical
 Sexual misconduct
 Sexual misconduct - Verbal

ADMINISTRATIVE PROBLEMS

Academic research fraud
 Billing for services not rendered
 Billing fraud (not Medicaid/Medicare)
 Breach of confidentiality
 False or deceptive advertising
 Inadequate documentation/patient records
 Insurance balance billing (not
 Medicaid/Medicare)
 Medicaid/Medicare
 Medicaid/Medicare balance billing

SUPERVISION

Fully licensed physician
 Limited licensee (e.g. resident)
 Nurse or other employee
 Physician's assistant

DIAGNOSIS RELATED

Delay in diagnosis
Failure to Diagnose
 Abdominal problems (not appendicitis or
 ulcer)
 AIDS/AIDS Related Complex/HIV
 Appendicitis
 Bladder problem
 Bone cancer
 Bowel problem
 Breast cancer
 Cancer (unspecified)
 Cardiac disorder (not myocardial infarction)
 Circulatory problem
 Colon/rectal cancer
 Diabetes
 Eye disorder
 Fracture/Dislocation
 Gall Bladder disorder
 Genetic disorder
 Hemorrhage
 Hernia
 Hodgkin's disease
 Implanted foreign body
 Infection
 Kidney disorder
 Liver disorder
 Liver/kidney/pancreas cancer
 Lung cancer
 Lyme disease
 Meningitis
 Myocardial infarction
 Neurological disorder
 Orthopedic problem (not
 fracture/dislocation)
 Ovarian/cervical cancer
 Pneumonia/pneumothorax
 Respiratory problem
 Skin cancer
 Tendon injury
 Testicular torsion
 Testicular/prostate cancer
 Tumor
 Ulcer or complication(s) of ulcer
 Failure to perform diagnostic test(s)
 Lack of informed consent
 Misdiagnosis
 Ordering/performing unnecessary diagnostic
 tests/procedures

**BIOMEDICAL EQUIPMENT/PRODUCT
RELATED**

Malfunction
 Misuse

TREATMENT RELATED

Abandonment of patient
 Delay in treatment
 Failure to make referrals appropriately
 Failure to monitor patient
 Failure to notify patient of test results
 Failure to take adequate patient history
 Failure to treat
 Failure to use consultants appropriately
 Improper choice of treatment
 Improper treatment of fracture/dislocation
 Inappropriate admissions(s)
 Inappropriate discharge(s)/transfer(s)
 Lack of informed consent

Anesthesia Related

General
 Allergic/adverse reaction
 Failure to test improper use of equipment
 Improper intubation
 Improper positioning of patient
 Lack of informed consent
 Teeth damage
 Wrong amount/type of anesthesia prescribed

Intravenous Related

CVP line
 Dye reaction
 General
 Infiltration
 Lack of informed consent

Medication Related

Drug side effect
 Drug toxicity/overdose
 Failure to diagnose drug addiction
 Failure to diagnose drug related problem(s)
 (not addiction)
 Failure to prescribe
 General
 Lack of informed consent
 Prescribing to a known addict
 Wrong dose of medication
 ordered/administered
 Wrong medication ordered/administered

Mental Illness Related

Failure to diagnose mental
 disorder/illness/problem
 Failure to warn third party(ies)
 General
 Improper commitment
 Improper use of seclusion/restraints
 Lack of informed consent
 Suicide/suicide attempt by inpatient
 Suicide/suicide attempt by outpatient

Obstetrics-Gynecology Related

Failed sterilization
 Failure to diagnose ectopic pregnancy
 Failure to diagnose Pregnancy, normal
 Fetal death/stillbirth
 Gynecology-general
 Improper performance of abortion
 Injury to child during labor/delivery
 Injury to mother during labor/delivery
 Lack of informed consent
 Maternal death related to delivery
 Obstetrics-general
 Wrongful life/birth

Surgery Related

Delay in surgery
 General
 Failure to diagnose post-op complications
 Improper treatment of post-op complication
 Improper/negligent performance
 Laceration/penetration not within scope of
 surgery
 Lack of informed consent
 Positioning-not anesthesia
 Retained foreign bodies (e.g. needle, sponge)
 Unnecessary surgery
 Wrong body part or wrong patient

Specified Procedures/Specialties

Angiography/arteriography
 Biopsy
 CAT scan/MRI
 Catheterization
 Chemotherapy
 Circumcision
 Colonoscopy
 Endoscopy
 Injection/Immunization
 Laparoscopy/laparotomy
 Myelography
 Neonatology
 Neurology
 Orthopedics
 Pediatrics
 Plastic/cosmetic surgery
 Radiation therapy
 Stress test
 Suturing

TRANSFUSION RELATED

Caused AIDS/HIV
 Caused hepatitis
 Mismatch

MISCELLANEOUS

Improper utilization review
 Improper Workmen's Compensation
 evaluation
 Patient fall (in health care facility/office)
 Performance of autopsy without permission
 Unauthorized DNR order
 Vicarious liability for acts of another provider
 Violation of patient's civil rights
 Wrongful death of patient