PodiatryPlan

# Application Form

Please include required documents listed on page 2 along with application.

Name ______________________________ ______ GENDER M ☐ F ☐
LAST FIRST MI DATE OF BIRTH

Office Address ______________________________ _ _ _ _ _-_ _ _ _
STREET CITY STATE ZIP

Residence Address ______________________________ _ _ _ _ _-_ _ _ _
STREET CITY STATE ZIP

Phone #s: Office ( ) ____________ Home ( ) ____________ Fax ( ) ____________

Personal Social Security # ____________ Billing Tax ID # or SS # ____________

State License # ____________ TIN # ____________ DEA Registration # ____________

Liability Insurance Company ____________ ______/______ ☐ Full Time ☐ Part Time

Ethnic / National Identity ____________ ☐ I choose not to answer

**Podiatry College**

Name____________ Year Graduated ____________ Degree ____________

**Post Graduate Education**

Type ____________ Hospital ____________ Year ____________
FROM TO

Type ____________ Hospital ____________ Year ____________
FROM TO

**Board Certifications**

Board ____________ Year Certified ____________

Board ____________ Year Certified ____________

**Memberships**

Organization ____________ Office Held ____________

Organization ____________ Office Held ____________

**Active Hospital Staff Memberships**

Hospital Name ____________ City ____________

Hospital Name ____________ City ____________

Do you hold a faculty position? ☐ Yes ☐ No ____________
INSTITUTION RANK

Please list any additional practice locations you may use:

Address ______________________________ _ _ _ _ _-_ _ _ _
STREET CITY STATE ZIP

PodiatryPlan

# Application Form

Please include required documents listed on this page along with application.

**Have You Had:**

Malpractice actions or pending suits brought against you in the last 7 years? ☐ Yes ☐ No
Malpractice settlements, judgements or arbitration proceedings? ☐ Yes ☐ No
Revocations or suspensions or limitations of hospital practice? ☐ Yes ☐ No
Suspensions as a Medicare or Medicaid provider? ☐ Yes ☐ No
Professional liability insurance cancellation in the past five years? ☐ Yes ☐ No
State licensing investigations or actions? ☐ Yes ☐ No
Any conviction of a felony, moral or ethical crime? ☐ Yes ☐ No
DEA licensing investigations or actions? ☐ Yes ☐ No
Any chronic illnesses, physical defects, or mental health conditions that would impair your ability to practice your specialty, or have you ever received any treatment for addiction to drugs or alcohol? ☐ Yes ☐ No
More than five percent ownership of any medical facility, joint ownership of medical services or equipment with a facility to which you might refer patients? ☐ Yes ☐ No

**Have you voluntarily surrendered or limited your:**

License to practice podiatry in any jurisdiction? ☐ Yes ☐ No
Staff privileges at any hospital/healthcare institution while under formal or informal investigation by the institution or a committee thereof? ☐ Yes ☐ No

**Please include an explanation for any question answered yes:**

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**Please submit the following with your completed and signed application and mail to Podiatry Plan:**

1. A copy of your current state license(s).
2. A copy of your DEA Certificate.
3. A copy of your Board Certification(s). If not board certified, when do you plan on taking the exam? Mo._____Yr. _____
4. Proof of malpractice coverage (the policy face sheet or certificate of insurance naming Podiatry Plan as certificate holder).
5. A copy of your curriculum vitae or 5 year work history.
6. A copy of your W-9 and any and all additional mailing, billing, or office addresses and phone numbers, and additional active staff hospital affiliations.
7. Any explanations requested elsewhere in this application.

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All information provided in this or in connection with this application is complete and accurate to the best of my knowledge and I shall immediately notify Podiatry Plan of any changes thereto. I understand that this application does not entitle me to participation in Podiatry Plan. I agree to the acquisition and communication of information pertaining to my qualifications by Podiatry Plan and other persons, including the following: hospitals, medical staffs, schools, professional societies, associations and insurance companies. Additionally, I agree that entities providing information in good faith, pursuant to this release, shall not be liable for any act or omission related to the evaluation or verification of information contained in this application. It is further understood that upon my review as a Podiatry Plan Participating Physician, I shall provide ready access and copies to Podiatry Plan, upon request, of any and all medical records that my office maintains for any Podiatry Plan members.

I hereby agree to the on-going acquisition and communication of information pertaining to my qualifications by Podiatry Plan and other persons, including hospitals, medical staffs, schools, professional societies, associations, and insurance companies as long as I am and agree to remain a Podiatry Plan Provider.

I authorize Podiatry Plan to obtain a copy of my file from the National Provider Data Bank and from any other state or federal agency, hospital, insurer, or professional society or association that maintains a file relating to my professional status or competence, all such files to be held confidential and used solely for the purpose of evaluating the within application, as required by law.

SIGNATURE

DATE

RECEIVED BY PODIATRY PLAN

CREDENTIALING DATE

LAST CREDENTIALING DATE