ABINGTON SURGICAL CENTER
We're in this together.

PROVIDER APPLICATION

Date_____

IDENTIFYING INFORMATION

Name _____

DOB: _____ Birthplace: _____

Eligible to work in U.S.? ☐ Yes SSN: _____

Visa Number_____ Visa Expiration _____

Race/Ethnicity (not required) _____ Sex: ☐ Male ☐ Female

Languages Spoken _____ Marital Status _____

Home Address _____

City, State, Zip Code _____

Cell: _____ Email: _____

Preferred Phone: _____ Preferred Email: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

NPI _____ UPIN _____

Medicare Provider? ☐ Yes ☐ No Medicare Provider Number_____

Medicaid Provider? ☐ Yes ☐ No Medicaid Provider Number_____

US Military/Public Health? ☐ Yes ☐ No Start Date _____ From Date_____

Branch of Service _____ Last Location_____ Currently Active or Reserve ☐ Yes ☐ No

CURRENT PRACTICE INFORMATION

Title/Position: _____

Practice Name: _____

DBA (if different from practice name): _____

Type of Practice: _____ Dept. Name (if hospital based): _____

Practice Federal Tax ID: _____ Practice NPI: _____

Practice Medicaid Number: _____

Currently Practicing? ☐ Yes ☐ No Start Date: _____

Location NPI: _____ Federal Tax ID Number: _____

Provider:

Location Legal Name: _____ Languages: _____

Office Address _____

City, State, Zip Code _____

Phone: _____ Fax: _____ Cell: _____

Office Appointment Phone: _____

Office Email Address: _____

Office Website: _____

Office Manager: _____ Office Mgr Phone: _____

Office Mgr Fax: _____ Office Mgr Email: _____

Credentialing Manager: _____ Cred Mgr Phone: _____

Cred. Mgr Fax: _____ Cred Mgr Email: _____

Billing Manager: _____ Billing Mgr Phone: _____

Billing Address: _____

PREMEDICAL EDUCATION ☐ **Not Applicable**

Institution Name: _____

Institution Department: _____

Degree Received: _____ Major: _____

Program Complete? ☐ Yes ☐ No Start Date: _____ End Date: _____

Mailing Address: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

MEDICAL EDUCATION ☐ **Not Applicable**

Please list information pertaining to medical school. If you are an allied health provider, you have the option to mark this section as "not applicable" and input your education in the postgraduation training section.

Institution Name: _____

Institution Department: _____

Degree Received: _____

Program Complete? ☐ Yes ☐ No Start Date: _____ End Date: _____

Mailing Address: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

POSTGRADUATE TRAININGS ☐ **Not Applicable**

Institution Name: _____

Institution Department: _____

Program Director: _____

Training Type: _____ Specialty: _____

Program Complete: ☐ Yes ☐ No If no, provide explanation: _____

Mailing Address: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

Institution Name: _____

Institution Department: _____

Program Director: _____

Training Type: _____ Specialty: _____

Program Complete: ☐ Yes ☐ No If no, provide explanation: _____

Mailing Address: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

Institution Name: _____

Institution Department: _____

Program Director: _____

Training Type: _____ Specialty: _____

Program Complete: ☐ Yes ☐ No If no, provide explanation: _____

Mailing Address: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

BOARD CERTIFICATIONS ☐ **Not Applicable**

Include certifications by board(s) which are duly organized and recognized by:

- A member board of the American Board of Medical Specialties
- A member board of the American Osteopathic Association
- A board or association with equivalent requirements approved by the Medical Board of California
- A board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty

Issuing Board: _____

Specialty: _____

If yes:

Board Certification Number: _____

Date Certified: _____ Date Recertified: _____

Expiration Date: _____

If no:

I am intending to sit for a board certification exam on: _____

OTHER CERTIFICATIONS ☐ **Not Applicable**

Number: _____ Expiration Date: _____ Issue Date: _____

Number: _____ Expiration Date: _____ Issue Date: _____

Number: _____ Expiration Date: _____ Issue Date: _____

Number: _____ Expiration Date: _____ Issue Date: _____

Number: _____ Expiration Date: _____ Issue Date: _____

Number: _____ Expiration Date: _____ Issue Date: _____

MEDICAL LICENSURE

DEA Registration Number: _____

Original Issue Date: _____ Expiration Date: _____

CDS Certificate: _____ State: _____

Original Issue Date: _____ Expiration Date: _____

ECFMG Number: _____ Original Issue Date: _____

Fifth Pathway- Institution: _____

Start Date: _____ End Date: _____

Provider:

STATE MEDICAL LICENSURE

State: _____ License Number: _____

Do you currently practice in this state? ☐ Yes ☐ No License Status: _____

Issue Date: _____ Expiration Date: _____

State: _____ License Number: _____

Do you currently practice in this state? ☐ Yes ☐ No License Status: _____

Issue Date: _____ Expiration Date: _____

State: _____ License Number: _____

Do you currently practice in this state? ☐ Yes ☐ No License Status: _____

Issue Date: _____ Expiration Date: _____

MALPRACTICE INSURANCE

Please list any professional liability insurance you have had over the last 10 years. Also list any professional liability insurance that has provided you coverage/defense in a lawsuit or arbitration action.

Current Insurance Carrier: _____ Policy Number: _____

Type of Coverage: _____ Effective Date: _____

Expiration Date: _____ Retroactive Date: _____ Per Claim Amount: _____

Aggregate Amount: _____ Did you purchase tail and/or nose coverage? ☐ Yes ☐ No

If yes, please supply details _____

Please explain any surcharges to your professional liability coverage _____

_____

Name of Insurance Contact: _____

Claims History Contact: _____

Phone: _____ Fax: _____

Email: _____ Department: _____

Website: _____

Mailing Address: _____

CLAIMS HISTORY ☐ **Not Applicable**

Please provide information for any pending, settled, or otherwise concluded professional liability lawsuit or arbitration filed and served against you, whether or not any payment was made on your behalf.

Date of Alleged Incident: _____ Date Suit Filed: _____ Age of Patient: _____

Name of Patient: _____ Sex of Patient: _____

Relationship to Patient: _____ Others Named in Suit: _____

Provider:

Address of Occurrence: _____

Location Type: _____ Location of Lawsuit: _____

Case Filed Against: _____

Court Case Number: _____

Allegation: _____

Was/Is there a liability protection organization provider coverage/defense? ☐ Yes ☐ No

Claim Status: _____ Amount Paid on Your Behalf: _____

Payment was attributable to: _____

Please provide a detailed summary of circumstances and clinical narrative. Include patient diagnosis and condition at time of incident, dates, and descriptions of treatment, and condition subsequent to treatment.

_____

_____

_____

_____

_____

_____

CURRENT HOSPITAL AFFILIATIONS ☐ **Not Applicable**

Do you have hospital privileges? ☐ Yes ☐ No If you do not admit patients, what admitting arrangements do you have? _____

Hospital Name: _____ Department: _____

Department Status (active, provisional, courtesy, etc.) _____

Title/Position: _____ Start Date: _____

Medical Office Contact: _____

Mailing Address: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

Full Unrestricted Privileges? ☐ Yes ☐ No Are Privileges temporary? ☐ Yes ☐ No

Types of Privileges? _____

What percentage of admissions to all hospitals in the past year is to this specific hospital? _____

Provider:

PAST HOSPITAL AFFILIATIONS ☐ **Not Applicable**

Hospital Name: _____ Department: _____

Title/Position Held: _____

Start Date: _____ End Date: _____ Reason for leaving: _____

Medical Office Contact: _____

Mailing Address: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

Hospital Name: _____ Department: _____

Title/Position Held: _____

Start Date: _____ End Date: _____ Reason for leaving: _____

Medical Office Contact: _____

Mailing Address: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

PEER REFERENCES

References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

Name of reference: _____

Title: _____ Specialty: _____

Relationship: _____ Known from: _____ Known To: _____

Phone: _____ Fax: _____

Email: _____

Mailing Address: _____

Name of reference: _____

Title: _____ Specialty: _____

Relationship: _____ Known from: _____ Known To: _____

Phone: _____ Fax: _____

Email: _____

Mailing Address: _____

Name of reference: _____

Title: _____ Specialty: _____

Relationship: _____ Known from: _____ Known To: _____

Phone: _____ Fax: _____

Email: _____

Mailing Address: _____

WORK HISTORY ☐ **Not Applicable**

Name of Practice/Employer: _____

Department: _____ Currently Working Here? ☐ Yes ☐ No

Title/Position Held: _____ Eligible for Rehire? ☐ Yes ☐ No

Start Date: _____ End Date: _____ Reason for Leaving: _____

Contact Name: _____

Mailing Address: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

Name of Practice/Employer: _____

Department: _____ Currently Working Here? ☐ Yes ☐ No

Title/Position Held: _____ Eligible for Rehire? ☐ Yes ☐ No

Start Date: _____ End Date: _____ Reason for Leaving: _____

Contact Name: _____

Mailing Address: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

EMPLOYMENT GAPS ☐ **Not Applicable**

Please provide an explanation of any gaps greater than six months in each work history.

Start Date: _____ End Date: _____

Explanation: _____

_____ _____ _____

Signature of Applicant Print Name Date

Provider:

COVERING PROVIDER

Facility Name: _____

Provider Name: _____

Provider Specialty: _____

Provider License Type: _____ Phone: _____

Email: _____

_____ _____ _____

Signature of Applicant Print Name Date

Provider: