



Please list ALL medical licenses, active or inactive.

State	Number	Date Issued	Expiration Date	State Controlled Substance #
State	Number	Date Issued	Expiration Date	State Controlled Substance #
State	Number	Date Issued	Expiration Date	State Controlled Substance #
DEA Registration Number		Date Issued	Expiration Date	Schedules
Please list any additional <b>active</b> licenses, with numbers				
In which state did you obtain your <b>original</b> license?				
Please list all additional <b>inactive</b> licenses, with numbers				

In addition to English, other languages spoken with communication ease and/or fluency \_\_\_\_\_

**IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING, PLEASE PROVIDE SIGNED and DATED EXPLANATION(S) ON A SEPARATE SHEET**

**DISCIPLINARY ACTIONS** Have any of the following ever been or are currently in the process of being investigated, denied, revoked, suspended, reduced, limited, placed on probation, not renewed, been subject to disciplinary action or voluntarily relinquished? **If yes, please provide full explanation on a separate sheet.**

Medical license in any jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prerogatives/rights on any medical staff?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other professional registration/license?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any medical organization or other institutional affiliation or status there at?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
DEA registration?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Professional society membership or fellowship/Board Certification	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Academic appointment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Professional office?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Membership on any hospital medical staff?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any other type of professional sanction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clinical privileges?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been convicted of a misdemeanor (other than minor traffic violation) or a felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Have there **ever been or are there currently pending**, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice?  Yes  No

Have you ever been denied, gone without, or not maintained Professional Liability Insurance?  Yes  No

Do you currently have any medical condition or use any chemical substance which impairs or limits your ability to practice medicine with reasonable skill and safety? **If yes, provide evidence that such conditions do not currently impair or limit your ability to practice medicine in your specialty with reasonable skill and safety.**  Yes  No

Within the past two (2) years, have you received treatment for alcoholism, drug abuse, or for any infectious disease, mental illness or psychiatric problem which could impair or limit your ability to practice medicine in your specialty with reasonable skill and safety? **If yes, provide evidence that such conditions do not currently impair or limit your ability to practice medicine in your specialty with reasonable skill and safety.**  Yes  No

Other than those circumstances noted above, is there anything in your personal or professional background that may surface during our credentials verification process that may be construed as derogatory or negative?  Yes  No

**REFERENCES** Please list a minimum of six (6) professional references with whom you have worked in the past two years and who can attest to your specific medical abilities

1. Name	Association	
Specialty	Home Phone ( )	Work Phone ( )
2. Name	Association	
Specialty	Home Phone ( )	Work Phone ( )
3. Name	Association	
Specialty	Home Phone ( )	Work Phone ( )
4. Name	Association	
Specialty	Home Phone ( )	Work Phone ( )
5. Name	Association	
Specialty	Home Phone ( )	Work Phone ( )
6. Name	Association	
Specialty	Home Phone ( )	Work Phone ( )

I certify that the information on this application is true to the best of my knowledge. I authorize all persons and institutions to disclose to and share with MSI opinions and information regarding me, including but not limited to, information contained in this application and my skills, experience, fitness to practice medicine, character, work habits, and performance. I authorize MSI to release information contained in this application or obtained by MSI pursuant to the authorization contained in this paragraph to MSI's insurance companies and medical facility clients. I waive any claims I might otherwise have against MSI resulting from MSI obtaining or releasing information as authorized by this paragraph.

PRINT NAME

SIGNATURE

DATE