"luv you to my heart"

41920 sixth street A-2. \ Temecula, CA 92590 \ 855.luv.u2mh

PRACTITIONER INFORMATION		
Name of business:		
Doctors name:		
Current address:		
City:	State:	ZIP Code:
Male ☐ Female ☐	Fax:	Phone number:
Practice website:	Email:	
Specialty primarily practicing:		
Degree(s):		
List any other name(s) under which you have been known by reference, licensing and or educational institutions:		
Sub specialties primarily practicing:		
Languages Fluently Spoken by Practitioner:		

PRACTICE INFORMATION		
Effective Date at Primary Practice location (MM/YY) _____ Practice Setting ☐ Clinic/Group ☐ Solo Practice ☐ Home Based ☐ Hospital Based ☐ Primary Care Site Urgent Care Other		
Practice address (if different from above):		
City:	State:	ZIP Code:
Phone:	E-mail:	Fax:
Office manager/administrator name:		
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Is the office wheelchair accessible? ☐ Yes ☐ No	Are you accepting new patients? ☐ Yes ☐ No	
Please list languages fluently spoken by office staff:		

PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS (ATTACH ADDITIONAL SHEET IF NECESSARY)					
California State Professional License/Registration/Cert Number:					
Issue Date:	Expiration Date:				
ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS					
State:	Lic/Reg/Cert #:	Date Issued	Exp. Date:	Yr. Relinquish	Reason:

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State:	Lic/Reg/Cert #:	Date Issued	Exp. Date:	Yr. Relinquish	Reason:

BOARD CERTIFICATION:
Are you board or otherwise professionally certified?

Board/Entity & State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)
Board/Entity & State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)

PROFESSIONAL LIABILITY (*DO NOT ABBREVIATE*)

Current Insurance Carrier:	Policy Number:	
Address:		
City:	State:	ZIP Code:
Phone:	Fax:	
Email:		

Per claim amount: $	Date Began:	Aggregate amount: $	Expiration Date:

CRIMINAL HISTORY

1. Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation? ☐YES ☐ NO
a. Do you have notice of any such anticipated charges? ☐YES ☐ NO
b. Are you currently under governmental investigation? ☐YES ☐ NO

AFFIRMATION OF ABILITIES

1. Do you presently use any drugs illegally? ☐YES ☐ NO
2. Do you have, or have you had in the last five years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance. ☐YES ☐ NO

3. Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance? ☐YES ☐ NO

D. LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section, please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)

1. Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit? ☐YES ☐ NO

2. Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court ordered damage award) in a professional lawsuit? ☐YES ☐ NO

3. Are there any such claims being asserted against you now? ☐YES ☐ NO
4. Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)? ☐YES ☐ NO

5. Are any of the privileges that you are requesting not covered by your current malpractice coverage? ☐YES ☐ NO

PROFESSIONAL REFERENCES

Name:	Profession:	
Address:		Phone:
City:	State:	ZIP Code:
Relationship:		

ATTESTATION

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Signature:	Date
Print name:	
Witness signature:	Print name: