

Professional IDs Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1

Personal Information and Professional IDs

Professional IDs

Include all additional state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/certifications.

If you need to report additional Professional IDs, photocopy this page as needed and submit as instructed.

FEDERAL DEA NUMBER

DEA ISSUE DATE

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE

FEDERAL DEA NUMBER

DEA ISSUE DATE

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE

CDS CERTIFICATE NUMBER

CDS ISSUE DATE

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE

CDS CERTIFICATE NUMBER

CDS ISSUE DATE

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE

LICENSE STATUS CODE

Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE

Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE

LICENSE STATUS CODE

Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE

Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

Additional Specialty Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3

Professional / Medical Specialty Information

Additional Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

SPECIALTY CODE	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	INITIAL CERTIFICATION DATE	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO	<input type="checkbox"/> YES <input type="checkbox"/> NO
BOARD CERTIFIED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	RECERTIFICATION DATE (IF APPLICABLE)	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	PPO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
CERTIFYING BOARD CODE	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	EXPIRATION DATE (IF APPLICABLE)	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	POS	<input type="checkbox"/> YES <input type="checkbox"/> NO	

IF NOT BOARD CERTIFIED (SELECT ONE) <input type="checkbox"/> I HAVE TAKEN EXAM, RESULTS PENDING FOR <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> CERTIFYING BOARD CODE	<input type="checkbox"/> I INTEND TO SIT FOR AN EXAM ON <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input type="checkbox"/> I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM
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IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Additional Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional Specialties, photocopy this page as needed and submit as instructed.

SPECIALTY CODE	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	INITIAL CERTIFICATION DATE	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO	<input type="checkbox"/> YES <input type="checkbox"/> NO
BOARD CERTIFIED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	RECERTIFICATION DATE (IF APPLICABLE)	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	PPO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
CERTIFYING BOARD CODE	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	EXPIRATION DATE (IF APPLICABLE)	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	POS	<input type="checkbox"/> YES <input type="checkbox"/> NO	

IF NOT BOARD CERTIFIED (SELECT ONE) <input type="checkbox"/> I HAVE TAKEN EXAM, RESULTS PENDING FOR <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> CERTIFYING BOARD CODE	<input type="checkbox"/> I INTEND TO SIT FOR AN EXAM ON <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input type="checkbox"/> I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.
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IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Practice Location Information - Page 4 of 5

Additional Practice Location
(Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

➔ **LOCATION* #**

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL

	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>
	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO

LANGUAGES INTERPRETED

	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>
	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

BUILDING?*	<input type="checkbox"/> YES <input type="checkbox"/> NO	TEXT TELEPHONY (TTY)*	<input type="checkbox"/> YES <input type="checkbox"/> NO	ACCESSIBLE BY PUBLIC TRANSPORTATION?*	<input type="checkbox"/> YES <input type="checkbox"/> NO
PARKING?*	<input type="checkbox"/> YES <input type="checkbox"/> NO	AMERICAN SIGN LANGUAGE*	<input type="checkbox"/> YES <input type="checkbox"/> NO	BUS*	<input type="checkbox"/> YES <input type="checkbox"/> NO
RESTROOM?*	<input type="checkbox"/> YES <input type="checkbox"/> NO	MENTAL/PHYSICAL IMPAIRMENT SERVICES*	<input type="checkbox"/> YES <input type="checkbox"/> NO	SUBWAY*	<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>		<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>		<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>
	OTHER HANDICAPPED ACCESS		OTHER DISABILITY SERVICES		OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

LABORATORY SERVICES? YES NO

IF YES, PROVIDE ACCREDITING/CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)

RADIOLOGY SERVICES? YES NO

IF YES, PROVIDE X-RAY CERTIFICATION TYPE

EKGS?	<input type="checkbox"/> YES <input type="checkbox"/> NO	ALLERGY INJECTIONS?	<input type="checkbox"/> YES <input type="checkbox"/> NO	ALLERGY SKIN TESTING?	<input type="checkbox"/> YES <input type="checkbox"/> NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DRAWING BLOOD?	<input type="checkbox"/> YES <input type="checkbox"/> NO	AGE APPROPRIATE IMMUNIZATIONS?	<input type="checkbox"/> YES <input type="checkbox"/> NO	FLEXIBLE SIGMOIDOSCOPY?	<input type="checkbox"/> YES <input type="checkbox"/> NO	TYPANOMETRY / AUDIOMETRY SCREENING?	<input type="checkbox"/> YES <input type="checkbox"/> NO
ASTHMA TREATMENT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	OSTEOPATHIC MANIPULATION?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IV HYDRATION/TREATMENT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	CARDIAC STRESS TEST?	<input type="checkbox"/> YES <input type="checkbox"/> NO
PULMONARY FUNCTION TESTING?	<input type="checkbox"/> YES <input type="checkbox"/> NO	PHYSICAL THERAPY?	<input type="checkbox"/> YES <input type="checkbox"/> NO	CARE OF MINOR LACERATIONS?	<input type="checkbox"/> YES <input type="checkbox"/> NO		

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? YES NO

IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT?

LAST NAME FIRST NAME

TYPE OF PRACTICE (SELECT ONE ONLY)*

SOLO PRACTICE SINGLE SPECIALTY GROUP MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Practice Location Information - Page 5 of 5

Additional Practice Location
(Continued)

→ LOCATION* #

IMPORTANT
In the box provided, indicate to which practice location this page belongs.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	SPECIALTY CODE		
<input type="text"/>	<input type="text"/>	<input type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	SPECIALTY CODE		
<input type="text"/>	<input type="text"/>	<input type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	SPECIALTY CODE		
<input type="text"/>	<input type="text"/>	<input type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	SPECIALTY CODE		
<input type="text"/>	<input type="text"/>	<input type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Professional Liability Insurance Carrier Supplemental Form

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6 Professional Liability Insurance Carrier

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

<input type="text"/>	SELF-INSURED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CARRIER OR SELF-INSURED NAME			
<input type="text"/>	<input type="text"/>	<input type="text"/>	
NUMBER*	STREET*	SUITE/BUILDING	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
CITY*	STATE*	ZIP CODE*	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ORIGINAL EFFECTIVE DATE*	EFFECTIVE DATE*	EXPIRATION DATE	TYPE OF COVERAGE?*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SHARED
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ <input type="text"/>	\$ <input type="text"/>
		AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE
POLICY INCLUDES TAIL COVERAGE?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="text"/>			
POLICY NUMBER*			

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

If you need additional space for Insurance Coverage, photocopy this page as needed and submit as instructed.

<input type="text"/>	SELF-INSURED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CARRIER OR SELF-INSURED NAME			
<input type="text"/>	<input type="text"/>	<input type="text"/>	
NUMBER*	STREET*	SUITE/BUILDING	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
CITY*	STATE*	ZIP CODE*	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ORIGINAL EFFECTIVE DATE*	EFFECTIVE DATE*	EXPIRATION DATE	TYPE OF COVERAGE?*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SHARED
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ <input type="text"/>	\$ <input type="text"/>
		AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE
POLICY INCLUDES TAIL COVERAGE?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="text"/>			
POLICY NUMBER*			

Work History Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7

Work History

Work History

Use this form to continue listing work history.

If you need additional space for Work History, photocopy this page as needed and submit as instructed.

WORK HISTORY

PRACTICE / EMPLOYER NAME											
NUMBER			STREET						SUITE/BUILDING		
CITY						STATE		ZIP/POSTAL CODE			
TELEPHONE			FAX								
			M M Y Y Y Y			M M Y Y Y Y					
COUNTRY CODE			START DATE			END DATE					
REASON FOR DEPARTURE (IF APPLICABLE)											

WORK HISTORY

PRACTICE / EMPLOYER NAME											
NUMBER			STREET						SUITE/BUILDING		
CITY						STATE		ZIP/POSTAL CODE			
TELEPHONE			FAX								
			M M Y Y Y Y			M M Y Y Y Y					
COUNTRY CODE			START DATE			END DATE					
REASON FOR DEPARTURE (IF APPLICABLE)											

