HAWAII PACIFIC NEUROSCIENCE, LLC

Employment Application

APPLICANT INFORMATION			
Last Name	First	M.I.	DOB
Street Address		Apartment/Unit #	
City	State	ZIP	
Phone	E-mail Address		
Date Available	Social Security No.		

Professional Liability Insurance Information:

(Copy of face sheet of policy must be attached)

Please list your current insurance carrier, as well as any other carriers you have been insured within the last five (5) years. Provide the carrier name, policy number and current expiration date.

Insurance Carrier:_____Policy #:_____
Policy Limits: Occurrence:_____ Aggregate: _____ Policy Type: Claims Made:_____ Occurrence: _____
Address:_____
Effective Date: _____Expiration Date:_____ Retroactive Date:_____

Past Carrier(s) for last 5 years:

Insurance Carrier:_____Policy #:_____
Policy Limits: Occurrence:_____ Aggregate: _____ Policy Type: Claims Made:_____ Occurrence: _____
Address:_____
Effective Date: _____Expiration Date:_____ Retroactive Date:_____

Insurance Carrier:_____Policy #:_____
Policy Limits: Occurrence:_____ Aggregate: _____ Policy Type: Claims Made:_____ Occurrence: _____
Address:_____
Effective Date: _____Expiration Date:_____ Retroactive Date:_____

1. Has your professional liability insurance ever been cancelled? Yes No
2. Are any specific medical procedures excluded from your coverage? Yes No
3. Have any professional judgments or claims settlement, including those in arbitration, been paid by you or on your behalf? Yes No
4. Is any formal or informal professional liability claim or lawsuit now pending against you? Yes No
5. Have any claims not involving litigation or arbitration been paid by you or on your behalf? Yes No
6. Have you had any liability cases against you dropped or dismissed? Yes No

Please provide detailed information on "Malpractice History Information" page to any of the questions to which you answered yes (attach separate sheet if needed).

Competency

Please answer the following questions. If you answer 'yes' to any, please provide a detailed explanation with dates and circumstances on an attached sheet.

1. Has your license to practice medicine in this state or any other state been denied, restricted, limited, suspended or revoked? Yes No

2. Has your DEA and/or CDS to prescribe medications in this state or any other state been denied, restricted, limited, suspended or revoked? Yes No

3. Are there any investigatory or disciplinary actions pending with respect to your license, DEA or CDS? Yes No

4. In the case where you have hospital privileges, have they ever been denied, suspended or revoked? Yes No

5. Have you ever had, or are there now pending, any disciplinary proceedings against you by a hospital? Yes No

6. Have you ever voluntarily surrendered your license, DEA, CDS, or any professional status? Yes No

7. Have you ever been denied membership or renewal thereof, or been subject to any disciplinary action by any professional organization? Yes No

8. Has your participation in Medicare, Medicaid, or any other government program ever been denied, restricted, limited, suspended or revoked? Yes No

9. To the best of your knowledge are you, or have you ever been, investigated with regard to Medicare, Medicaid, or any other government program? Yes No

10. Have you ever been subject to any disciplinary actions or have you ever been terminated for cause, or not renewed for cause, by any managed care organizations, health maintenance organizations, or preferred provider organizations, or any other managed care program? Yes No

11. Have you ever been convicted, pled guilty, or pled nolo contendere to a criminal offense? Yes No

12. Do you currently use illegal drugs? Yes No

13. Do you use chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? Yes No

14. Have you ever been convicted of, pled guilty, or pled nolo contendere to any administrative, civil, or criminal complaint or investigation regarding sexual misconduct? Yes No

15. Are you prevented in any way from performing the essential functions of your job with or without reasonable accommodation? Yes No

16. Have you had any gaps of greater than six months in your professional education or work history? Yes No

Attestation and Release

By signing this application, I attest that all of the information submitted in this application is true, correct and complete to the best of my knowledge and belief. I understand that any misstatement or omissions from this application may constitute cause for denial of my application, or if subsequently discovered, to termination.

I understand and agree that I, as an applicant, have the burden of producing adequate information that is true, correct and complete to the best of my knowledge and belief, for proper evaluation of my professional competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications. I understand that I have the right to correct erroneous information and the right to review information obtained to evaluate my credentialing application unless disclosure is prohibited by law or the information is protected by peer review.

_____

Physician Signature *Date*

_____ *Print Name*