County of Riverside Community Health Agency, Department of Public Health

CHILD HEALTH AND DISABILITY
PREVENTION PROGRAM

PROVIDER APPLICATION PART II

Individual Provider Information

*(One copy must be completed by **each** MD/ IPA /NP seeking approval to provide CHDP services)*

PLEASE COMPLETE IN FULL:

I. IDENTIFICATION INFORMATION:

NAME: _____
Last Name First Name Middle Name

National Provider Identification Number: _____

■ FACILITY NAME: _____

II. BOARD CERTIFICATION:

_____ _____ _____
Complete Name of Board Board Status Date Certified/Re-certified

_____ _____ _____
Complete Name of Board Board Status Date Certified/Re-certified

III. HOSPITAL AFFILIATIONS: (Current and Pending)

_____ _____
Hospital #Admits/Month

Type of privileges at hospital listed above _____

_____ _____
Hospital #Admits/Month

Type of privileges at hospital listed above _____

IV. LICENSING INFORMATION:

_____ _____ _____
California License Number Expiration Date Social Security Number

_____ _____ _____
DEA Number Expiration Date Federal Tax ID Number

V. EDUCATION:

Medical School - Name of Institution — Date From To

City/ State/ Country — Degree-Received

Residency/ Internship - Specialty — Date From To

Name of Institution

City/ State/Country — Name of Program Chairperson

VI. PROFESSIONAL LIABILITY:

If the answer to any of the following questions is YES, please give full details and explanation on attached sheet, including dates, location of the court, names of the parties in the case(s), and disposition of the case.

☐ Yes ☐ No 1. Do you have any malpractice suits pending against you currently?

☐ Yes ☐ No 2. Have you ever had a malpractice suit(s) filed against you?

☐ Yes ☐ No 3. Have you ever settled a malpractice suit against you?

☐ Yes ☐ No 4. Have you ever had a judgment(s) entered against you in a malpractice case?

☐ Yes ☐ No 5. Have you reported a malpractice claim to your insurance carrier?

6. Name of your current malpractice insurance carrier:

VII. **LICENSE/CERTIFICATION**:

If the answer to any of these questions is YES, please give full details and explanation on attached sheet.

☐ Yes ☐ No 1. Have you ever been convicted of a felony?

☐ Yes ☐ No 2. Do you have any felony charges pending?

☐ Yes ☐ No 3. Have you ever had your medical staff privileges or status at any hospital or health care facility limited, suspended, revoked, subjected to probationary conditions, or denied - or is any action pending?

☐ Yes ☐ No 4. Have you ever resigned or surrendered clinical privileges from a medical staff while under investigation for possible incompetence or improper professional conduct or in return for such an investigation not being conducted?

☐ Yes ☐ No 5. Have you ever been denied membership or fellowship or renewal thereof, in a professional organization or society, or has your participation been limited, suspended, revoked, or subjected to probationary conditions - or is any action pending?

☐ Yes ☐ No 6. Has your license to practice medicine in any jurisdiction ever been limited, suspended, revoked, denied, or subjected to probationary conditions - or is any action pending?

☐ Yes ☐ No 7. Has your Drug Enforcement Administration registration ever been limited, suspended, revoked, denied, or subjected to probationary conditions - or is any action pending?

☐ Yes ☐ No 8. Have you voluntarily relinquished your license to practice medicine or your Drug Enforcement Administration (DEA) registration?

☐ Yes ☐ No 9. Has your specialty board eligibility or certification ever been reduced, suspended, revoked, or denied, or have proceedings ever been instituted against you?

☐ Yes ☐ No 10. Have you ever been or are you under investigation by a regulatory agency, e.g. Medi-Cal, Medicare, BMQA?

☐ Yes ☐ No 11. Have you ever been de-certified as a CHDP Provider in any county?

VIII. PRESENT STATUS:

1. What is your present practice status? ☐ Full Time ☐ Part Time

2. Are you able to perform all procedures for which you have requested privileges in accordance with accepted standards of professional performance and without posing a direct threat to patients? ☐ Yes ☐ No

The undersigned hereby acknowledges and agrees that the above information and any information provided on attachments hereto, is truthful, correct, and complete to the best of my knowledge and belief. The undersigned further understands that the submission of false or misleading information or the withholding of relevant information is grounds for termination or refusal of acceptance of the applicant by the Child Health and Disability Prevention Program. The undersigned further agrees to notify in writing the Child Health and Disability Prevention Program in the event of any change(s) in the above information which occurs after signature and dating of this form, while this application is pending, and if I have been granted approval, while enrolled as a provider of Child Health and Disability Prevention Program Services.

Provider Applicant signature *IN BLUE INK ONLY*	Date