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**Current Professional Liability Insurance:**

Carrier: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

ZIP

Policy Number: \_\_\_\_\_

Original Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Policy Limits: Per Occurrence: \$ \_\_\_\_\_ Aggregate: \$ \_\_\_\_\_

Retroactive Date: \_\_\_\_\_

**Please answer the following questions to the best of your knowledge with a “yes” or ‘no.’ If you answer “yes” to any question(s), please attach an explanation for each “yes” answer.**

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn?  Yes  No
  
2. Have you ever been reprimanded and/or fined, been subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers?  Yes  No
  
3. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank?  Yes  No
  
4. Has your federal DEA number and/or state controlled substance license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration?  Yes  No
  
5. Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, place under mandatory consultation or non-renewal?  Yes  No
  
6. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital

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- or ambulatory surgery center privileges for any reason?  Yes  No
7. Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license?  Yes  No
8. Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs?  Yes  No
9. Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues?  Yes  No
10. Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO or PRO?  Yes  No
11. Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review of an adverse decision?  Yes  No
12. Have you ever voluntarily or involuntarily relinquished, or ever withdrawn your membership on any hospital medical staff?  Yes  No
13. Have any professional liability judgments ever been entered against you?  Yes  No
14. Have any professional liability claim settlements ever been paid by you and/or paid on your behalf?  Yes  No
15. Are there any currently pending professional liability suits, actions and/or claims filed against you?  Yes  No
16. Has any person or entity ever been sued for your clinical actions?  Yes  No
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17. Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, and/or have had your professional liability insurance coverage canceled, non-renewed or limits reduced?

Yes  No

18. Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state of the country?

Yes  No

19. Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse?

Yes  No

20. Do you have any medical condition, physical defect or emotional impairment that in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety?

Yes  No

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**AUTHORIZATION**

I authorize The Neurologic & Orthopedic Institute of Chicago, or any affiliate of The Neurologic & Orthopedic Institute of Chicago, to obtain from any hospital, clinic, educational institution, professional organization, government agency, third party payor, professional liability carrier, or any other individual or entity with whom I have been associated, all information pertaining to my education, professional background and training, competence, or character, including without limitation, all education transcripts, records and reports; all professional liability claims histories and reports; records pertaining to professional discipline; records of any medical society or professional review organization including records arising out of any charges against me; hospital credentialing records, including records relating to any claim for limitation, denial, or suspension of my hospital privileges; all employment files, including all reports, evaluations, and records of disciplinary proceedings; and records relating to credentialing by a third party payer or governmental agency, including but not limited to information from the National Practitioner’s Data Bank. Any entity who has information pertinent to the foregoing is authorized to discuss the information with agents or representatives of The Neurologic & Orthopedic Institute of Chicago, and to provide them with access and copies of any records pertaining to such information. I recognize that some of the information which I have authorized to be released to The Neurologic & Orthopedic Institute of Chicago may be confidential under applicable laws, bylaws, policies, or agreements. I authorize the release of such information to The Neurologic & Orthopedic Institute of Chicago, notwithstanding its confidential nature.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**