MERCY HEALTH CLINIC
OF NORTH WAKE

Appendix B

TO BE COMPLETED BY LICENSED HEALTHCARE WORKERS

(Doctors, Nurse Practitioners, Physician Assistants, Registered Nurses, Licensed Vocational Nurses, Phlebotomists, Registered Dietician/Nutritionist, Social Worker, Counselor)

Name: _____

Occupation/Specialty: _____

CPR/ACL certified: Yes_____ (Certification Date: _____) No___

Are you currently licensed to practice in the State of North Carolina? Yes___ No___
Medical License #/Certification: _____
(Please attach a copy of license/certification)

Do you have mal practice insurance? Yes___ No___
If yes, please provide policy Information: _____

Do you suffer from any disability, transmittable diseases (i.e. Hepatitis, H.I.V, etc) or any other impediment which may affect the performance of your professional duties or place patients/clients at risk? Yes___ No___
If yes, please explain what accommodations are needed to ensure patient/client safety:
_____

For Practitioners and RNs:

What hospitals do you currently hold privileges?

Please provide the name and address of your current employer.

Please circle Yes or No for the following questions, then provide a complete, detailed explanation on a separate sheet for any of the following questions answered "yes".

1. Yes No Has your profession license or registration ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished, or not renewed by any licensing board or health related agency or organization, or is there a review pending?

2. Yes No Has your DEA registration ever been revoked, suspended, limited, or conditioned in any way, or have you ever voluntarily relinquished your DEA registration, or is there a review pending?

3. Yes No Has your membership, participation, clinical privileges, or employment ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked or not renewed by any peer review organization, third party, clinic, hospital, medical staff, or any health related agency or organization, or is there a review pending?

4. Yes No Have you ever voluntarily or involuntarily relinquished your membership, participation, clinical privileges or request for privileges, employment, professional license or registration as an alternative to disciplinary action, or prior to or during an investigation into your professional conduct or competence?

5. Yes No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subjected to a corrective action plan with any licensing board, peer review organization, third party payer, clinic, hospital, medical staff, or any health related agency?

6. Yes No Has your certificate or participation in any private, federal (i.e. Medicare, Medicaid), or state health insurance program ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?

7. Yes No Are there any charges pending or are you currently charged with or have you ever been indicted or found guilty of a felony or misdemeanor (other than a minor traffic violation) or other offense involving fraud, misrepresentation, dishonesty, or deceit?

8. Yes No Have you ever been the subject or target of a sexual or racial harassment complaint or investigation or other complaint or investigation involving sexual or other misconduct or impropriety?

9. Yes No Have you ever been a party to any lawsuit, including, but not limited to any professional liability claims or lawsuits brought against you. Including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments? If yes, please provide the following items for each matter: (i) the parties to the lawsuit; (ii) the date the lawsuit was filed; (iii) the court in which the lawsuit was filed; (iv) a description of the nature of the lawsuit and the claims made by the parties; and (v) the outcome of the lawsuit and the date in which it was resolved.

10. Yes No Has your professional liability carrier ever refused or canceled your coverage?

11. Yes No Have you changed medical malpractice insurance carriers in the last 5 years?

12. Yes No Have you ever been convicted of using illegal drugs?

13. Yes No Have you ever been convicted of driving under the influence?

14. Yes No Do you have any entries in the National Practitioner Data Bank?

I declare that the statements and particulars contained in this appendix and any accompanying documents (if any) that I provided are true and complete and that I have not miss-stated or suppressed any material facts.

Signature: _____ Date: _____