MALPRACTICE HISTORY AND STATUS QUESTIONNAIRE

(For use of this form, see USMEPCOM Reg 40-2)

PRIVACY ACT STATEMENT

Authority: Title 5, United States Code (USC), Sections 301 and 552a; Title 44, USC, Section 3101; Title 10, USC, Section 1071.

Principal Purpose: To document the provider's professional qualifications as the basis for medical services appointment.

Routine Uses: To support the Provider Quality Management Program (PQMP). A copy of this form will be retained in the provider's PQMP file. Information may be provided to certain civilian institutions, the Federation of State Medical Boards of the U.S., State Licensure Authorities, and other appropriate professional regulatory bodies.

Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information may interfere with the timely granting of your medical services appointment.

1. Full Name: *(Last, First, Middle, as applicable)*	2. National Provider Identifier (NPI):	3. Date of Birth: *(MMM DD, YYYY)*

1a. *(Maiden Names & Aliases, as applicable)*

4. Function: ☐ CMO ☐ Asst CMO (ACMO) ☐ Fee Basis Provider (FBP) 5. MEPS:

6. Place a mark (X) in the column that corresponds to your answer to each of the following questions below. (Any "YES" answer must be fully explained either on the bottom or back of this page in block 7). Supplemental and supporting documentation is encouraged to be submitted on questions with a "YES" answer. **Note: An answer is required for every question.**

YES	NO	ARE YOU NOW OR HAVE YOU EVER:
☐	☐	a. Been denied staff appointment or had your privileges suspended, limited, revoked, or denied a renewal?
☐	☐	b. Been the subject of a malpractice claim? (Indicate final disposition or current status of claim)
☐	☐	c. Been a defendant in a felony or misdemeanor case? (Indicate final disposition of case)
☐	☐	d. Had any successful or currently pending challenge, investigation(s), revocation, restriction, disciplinary action taken, suspension, reprimand, probation, denial, or withdrawal to any license, certification, or registration (Federal or State) to practice in any jurisdiction, or the voluntary or involuntary relinquishment of your license, certification, or registration?
☐	☐	e. Been refused membership in an institution's medical staff?
☐	☐	f. Been denied membership, or renewal thereof, or been subject to disciplinary action in any medical/osteopathic/nursing organization?
☐	☐	g. Been suspended, sanctioned, or otherwise restricted from participating in any private, local, state or federal health insurance programs (i.e., Medicare or Medicaid)?
☐	☐	h. Voluntarily or involuntarily resigned or otherwise disassociated yourself from employment or practice after being notified of the intent to initiate action against you for failure to properly execute your professional responsibilities?
☐	☐	i. Been involved in the unlawful use of a controlled substance?
☐	☐	j. Had medical liability claims, settlements, judicial or administrative adjudications, or any other resolved or open charges of inappropriate, unethical, unprofessional or substandard professional practice?
☐	☐	k. Been hospitalized or diagnosed with a psychiatric disorder?
☐	☐	l. Ever received treatment for an alcohol or drug-related condition or incident?
☐	☐	m. Had any condition that could affect your ability to perform in a safe and competent manner, either mental and or physical function that can relate to the specific clinical duties you are going to perform with USMEPCOM?
☐	☐	n. Had any change in work status during the last reporting period?
☐	☐	o. Had any changes to the status of your license(s) during the last reporting period?
☐	☐	p. Had any arrests or legal issues during the last reporting period?

7. **Comments:** Note which item, by number, you are explaining (i.e. 6a., 6b, etc.) and provide clarification on any question with a "YES" answer. (Include supporting documention as needed):

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1. Full Name: *(Last, First, Middle, as applicable)*

7. **Comments (continued)**
Note which item, by number, you are explaining (i.e. 6a., 6b., etc.) and provide clarification on any question with a "YES" answer. (Include supporting documentions as needed):

8a. Provider's Signature:	8b. Date Signed *(MMM DD, YYYY)*