MEDICAL PROVIDER INITIAL APPLICATION

(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.

SECTION A - IDENTIFICATION

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

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

4. Function:	5. MEPS:

SECTION B - PROFESSIONAL MEDICAL EDUCATION

6a. Name of Professional School:	6b. Type of Degree:	6c. Degree Completion Date: *(MMM DD, YYYY)*

SECTION C - POSTGRADUATE TRAINING AND LICENSING

7a. Name of Hospital or Institution:	7b. Location: *(City, State, Country)*	7c. Type of Program: *(Internship, Residency, Fellowship)*	7d. Date Completed: *(MMM DD, YYYY)*

8a. List All Active, Inactive, Current and Past State Licenses Ever Held:		8b. Status:	8c. Expiration Date: *(MMM DD, YYYY)*
State:	License number:	☐ Active ☐ Inactive	
State:	License number:	☐ Active ☐ Inactive	
State:	License number:	☐ Active ☐ Inactive	
State:	License number:	☐ Active ☐ Inactive	
State:	License number:	☐ Active ☐ Inactive	
State:	License number:	☐ Active ☐ Inactive	
State:	License number:	☐ Active ☐ Inactive	

The information contained herein is true to the best of my knowledge.	9a. Signature of Medical Provider Candidate:	9b. Date: *(MMM DD, YYYY)*

SECTION D - HEADQUARTERS REVIEW AND APPROVAL

10a. Provider Review Panel Physician: *Printed Name, Title* *Signature*	10b. Date *(MMM DD, YYYY)*	10c. Recommendation: ☐ Approve ☐ Disapprove *(If "Disapprove", insert comments below or provide MFR accordingly)*

10d. Comments/Remarks: *(If "Disapprove", insert comments below or provide MFR accordingly)*

11a. Command Surgeon or Authorized Designee: *Printed Name, Title* *Signature*	11b. Date *(MMM DD, YYYY)*	11c. ☐ Approved ☐ Disapproved

11d. Comments/Remarks: *(If "Disapprove", insert comments below or provide MFR accordingly)*

MEDICAL PROVIDER INITIAL APPLICATION CONTINUATION PAGE

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

SECTION E - ADDITIONAL INFORMATION/COMMENTS

12a. Signature of Individual Providing Additional Information/Comments :	12b. Date Signed *(MMM DD, YYYY)*