

# ★ Physician Credentialing Application

## ★ Authorization to Release and Investigate Records

*Please complete this application in its entirety. Print or type information clearly.*

Thank you for your interest in VitalMD Group Holding, LLC (“VitalMD”) and its subsidiary LLCs. VitalMD was founded to serve as the holding company for several medical practices. VitalMD’s mission is to provide ownership and management solutions that give physicians control over their practices while combining strength and skills to improve the quality of healthcare to their patients. Membership is limited to physicians who have established reputations for providing high quality OB-GYN services. As a member, you become a partial owner of VitalMD. Physician members, associates, and employees are employed by individual practices that are subsidiaries of VitalMD.

VitalMD has entered into an agreement with a management services organization that provides administration services, known as Femwell, in the areas of expansion, contract negotiations, billing, collections, accounting, risk management and HR to each of the subsidiaries in accordance with the services agreement. It is mandatory that all prospective physician members complete the attached application to begin the due diligence process necessary to form a wholly-owned subsidiary that provides medical services to patients along with membership opportunities.

### Main Office Location

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_ Suite/Floor: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Back Line: \_\_\_\_\_

Fax: \_\_\_\_\_

Office Administrator/  
Manager: \_\_\_\_\_ Extension: \_\_\_\_\_

Beeper or Cell Phone (If applicable): \_\_\_\_\_

Type of practice:     Solo     Group     Partnership

Days of Operations: \_\_\_\_\_

Business Hours: \_\_\_\_\_

Type of Entity:     Corporation     Partnership     LLC     Other: \_\_\_\_\_

If a Corporation:     C-Corp. or     S-Corp.

Federal Tax ID Number: \_\_\_\_\_ - \_\_\_\_\_

The Name this Tax ID # is registered to with the IRS: \_\_\_\_\_

Date business started: \_\_\_\_\_

# Physician Professional Profile

*(Each physician and/or medical provider in your group must complete a separate application)*

Physician's Name: \_\_\_\_\_  M.D.  D.O.  OTHER

Other Previous Name(s) Used: \_\_\_\_\_

Current Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Yrs. \_\_\_\_\_ Mo. \_\_\_\_\_

*If less than 5 Years at Current Address, please list previous address:*

Previous Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Yrs. \_\_\_\_\_ Mo. \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## Education

Undergraduate: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
*Name of School Year Year*

Completed/Degree?  Yes  No Major/Course of Study: \_\_\_\_\_

Graduate: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
*Name of School Year Year*

Completed/Degree?  Yes  No Major/Course of Study: \_\_\_\_\_

Medical School: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
*Name of School Year Year*

Completed/Degree?  Yes  No Major/Course of Study: \_\_\_\_\_

Post Graduate: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
*Name of School Year Year*

Completed/Degree?  Yes  No Major/Course of Study: \_\_\_\_\_

Other: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
*Name of School Year Year*

Completed/Degree?  Yes  No Major/Course of Study: \_\_\_\_\_

## Clinical Training

Internship #1: \_\_\_\_\_ From: \_\_\_\_\_ To \_\_\_\_\_  
*Name/Location of Program*  
Completed?  Yes  No Specialty: \_\_\_\_\_

Residency #1: \_\_\_\_\_ From: \_\_\_\_\_ To \_\_\_\_\_  
*Name/Location of Program*  
Completed?  Yes  No Specialty: \_\_\_\_\_

Fellowship #1: \_\_\_\_\_ From: \_\_\_\_\_ To \_\_\_\_\_  
*Name/Location of Program*  
Completed?  Yes  No Specialty: \_\_\_\_\_

Other: \_\_\_\_\_ From: \_\_\_\_\_ To \_\_\_\_\_  
*Name/Location of Program*  
Completed?  Yes  No Specialty: \_\_\_\_\_

## Specialty Boards

Primary: \_\_\_\_\_ Practicing?  Yes  No  
*Medical Specialty Board*  
 Eligible  Certified Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Secondary: \_\_\_\_\_ Practicing?  Yes  No  
*Medical Specialty Board*  
 Eligible  Certified Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Other: \_\_\_\_\_ Practicing?  Yes  No  
*Medical Specialty Board*  
 Eligible  Certified Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

When did you begin practicing medicine?: \_\_\_\_\_

UPIN #: \_\_\_\_\_ CLIA#: \_\_\_\_\_ DEA#: \_\_\_\_\_

Medicare Provider:  Yes  No Provider #: \_\_\_\_\_

Medicare Group #:  Yes  No Group #: \_\_\_\_\_

Medicaid Provider:  Yes  No Provider #: \_\_\_\_\_

Group #: \_\_\_\_\_

Medical License #: \_\_\_\_\_

If licensed in another state(s), please indicate below:

State: \_\_\_\_\_ License #: \_\_\_\_\_

State: \_\_\_\_\_ License #: \_\_\_\_\_

State: \_\_\_\_\_ License #: \_\_\_\_\_

Other Certifications: 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

### **Professional Liability (Malpractice) Insurance Information**

Please list your current professional liability insurance carrier:

Company Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy #: \_\_\_\_\_ Policy Period: \_\_\_\_\_ to \_\_\_\_\_

Other Coverage Arrangements:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Your response to the following questions should include the period of time beginning when you were first licensed in this or any other state through the present. Explain any affirmative response by attaching additional pages if necessary.

- 1. Has your license to practice medicine in any jurisdiction been surrendered, suspended or revoked?  Yes  No
- 2. Have you been refused membership on any hospital staff?  Yes  No
- 3. Have your privileges at any hospital been suspended, diminished, revoked or not renewed?  Yes  No
- 4. Have you surrendered your narcotics registration, or has it been suspended or revoked?  Yes  No
- 5. Are you, or have you been, subject to suspension as a Medicare or Medicaid provider?  Yes  No
- 6. Have you been, or are you presently the subject of an investigation by any state or federal regulatory agency regarding your professional activities?  Yes  No
- 7. Have you or any of your associates, or has your organization ever been dismissed for cause or canceled by any health plan, health insurance company or governmental program?  Yes  No
- 8. Are you, or have you ever been subject to conviction of a felony, moral or ethical crime?  Yes  No
- 9. Are you, or have you ever been denied professional liability or malpractice insurance or has your policy ever been cancelled?  Yes  No
- 10. Has a malpractice claim or lawsuit ever been brought against you? (Including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments).  Yes  No

*If you answered YES to this question, please complete the following:*

**If you answered YES to disclosure question #10, please provide the following detailed information for each malpractice claim brought against you, including pending claims, lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments. (Please explain any additional claims on a separate sheet, using this format).**

Date of Occurrence: \_\_\_\_\_ Amount paid/in reserve claim: \$ \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_

Insurance Carrier Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Current Status of Claim:  Open  Closed  Pending  Resolved

Details of Allegations: \_\_\_\_\_

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List any Department of Professional Regulation disciplinary actions within the past two years, and/or any other written explanations to the questions in this form, in the space provided or by attaching additional pages.

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**Please attach the following documentation to this application:**

- \_\_\_\_\_ 1. A copy of your Curriculum Vitae
- \_\_\_\_\_ 2. A copy of your Board Certification(s) or letter(s) of eligibility
- \_\_\_\_\_ 3. A copy of your Florida Medical License
- \_\_\_\_\_ 4. A copy of your City Occupational License
- \_\_\_\_\_ 5. A copy of your DEA license
- \_\_\_\_\_ 6. A copy of your current Professional Malpractice Insurance Policy.

# Release of Liability & Information

To the fullest extent permitted by law, the applicant extends absolute immunity to and releases from liability the Released Parties (as that term is hereinafter defined) from any and all civil liability which might arise from any acts, communications, reports, recommendations, inquiries, disclosures, or investigations committed or made in good faith and without malice, which involve any facet of granting, denying, limiting, revoking, terminating, monitoring, investigating, or otherwise affecting in any way the applicant's application for membership. The release extends to all matters of direct or privileged or confidential information. This release applies to the applicant's application for or holding of medical staff appointment or privileges at the hospital, as well as to information furnished by the group or any representative of this group to any other health care facility, licensing board, professional organization, or governmental authority regarding any matter directly or indirectly relevant to the applicant's application for or continued enjoyment of any license or affiliation of any nature with any of the foregoing. This release is irrevocable and shall be valid in perpetuity. As used herein, the term "Released Parties" means the group, its shareholders, officers, directors, employees, agents, representatives, trustees, officers of the Board, members of any committees of the group, any person furnishing information or consulting with or for, or advising any other Released Party on any matter pertaining to the applicant.

By submitting this application to Femwell, I hereby authorize the Administrator or representative to make any inquiry of any of my references and institutions which I have been enrolled or by whom I have been employed or extended privileges, as to my qualifications. I further authorize any of the above persons or institutions to forward any and all information their records may contain, and agree to hold them harmless from any action by me for their acts. In addition, I understand and consent to the examination of my professional, educational, technical and other qualification to which I have attested in this application. This includes employment, malpractice, criminal, credit, educational, licensure, staff appointments, facility privileges, and any other information I have provided herein.

A photocopy of this shall serve as the original.

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Print or type full name

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Signature

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Date

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Witness

