

my private practice, to travel but keep the same patients over time, to keep my clinical skills up while doing research, to bridge to another job, etc):

Please describe in detail any and all experience you have with telemental health:

Section B – Physician’s Medicare UPIN and PIN **(Provide these numbers below if available.)**

UPIN:

PIN:

Section C – National Provider Identifier (NPI) **(You must provide this number below to process application)**

NPI:

D. EMPLOYMENT/ WORK HISTORY - Current and/or Previous (last 10 years) In addition to the list of information below, please email a very detailed and current Curriculum Vitae to Dr. John Schaeffer at j.schaeffer@caltelepsych.com.

E. PROFESSIONAL EDUCATION (Provide any Internship, Residency, Fellowship information here.)

Institution	City / State	Type of Program	Graduation Year
1.			
2.			
3.			
4.			
5.			
6.			
7.			

F. PROFESSIONAL LICENSES & PROVIDER NUMBERS – Please email a copy of all professional license(s) to Sherry Ikeda at s.ikeda@caltelepsych.com.

State	Type of License	License Number	Expiration Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
<u>Complete only if applicable:</u>	DEA Number:	DEA Expiration Date:	

G. BOARD CERTIFICATIONS

Name of Board	Certification Date	Expiration Date
1.		
2.		
3.		
4.		
5.		
6.		

H. INSURANCE/ MALPRACTICE LIABILITY INFORMATION

Current Insurance Company and Coverage Information: Please attach a copy of the current policy

Carrier Name	Telephone #	Fax #
Street Address	City/State/Zip	Claim Limit
Effective Date	Expiration Date	Aggregate Limit

Previous Insurance Company List all Insurance Companies Within the Past Ten (10) years:

Carrier Name 1	Telephone #	Fax #
Street Address	City/State/Zip	Claim Limit
Effective Date	Expiration Date	Aggregate Limit
Carrier Name 2	Telephone #	Fax #
Street Address	City/State/Zip	Claim Limit
Effective Date	Expiration Date	Aggregate Limit
Carrier Name 3	Telephone #	Fax #
Street Address	City/State/Zip	Claim Limit
Effective Date	Expiration Date	Aggregate Limit
Carrier Name 4	Telephone #	Fax #
Street Address	City/State/Zip	Claim Limit
Effective Date	Expiration Date	Aggregate Limit

J. PROFESSIONAL HISTORICAL DATA ATTESTATION

Please answer all questions below. If you answer "Yes" to any question, please provide a detailed explanation in the space provided below. Explanation should include dates, circumstances of the incident, final outcome, current disposition, etc.

1. Yes No Has your license or certification been denied, restricted, suspended, revoked, surrendered, put on probation or issued on a restricted basis?
2. Yes No NA DEA registration ever suspended, revoked, or otherwise limited in any state?
3. Yes No Have any insurers canceled coverage, declined coverage, refused renewal or renewed only under restrictive circumstances your professional liability coverage?
4. Yes No Have you ever been denied professional liability insurance coverage or rated in a high-risk class for your professional specialty?
5. Yes No Are you currently being, or have you ever been, treated for the consumption or effects of alcohol or drugs?
6. Yes No Do you suffer from any physical or psychological illness, problem, injury or health condition which may limit, impair, or affect your ability to practice?
7. Yes No To your knowledge, has any information pertaining to you ever been reported to the National Practitioner Data Bank?
8. Yes No Have you ever been denied membership or renewal thereof, or been subject to probation, reprimand, censure, sanction, under investigation or disciplined by any health care organization, including but not limited to hospitals, health care facilities, HMOs, PPOs, independent practitioner associations, professional associations, groups or societies, ethics committee, state licensing boards, certification boards or examiners, professional standards review organization (PSRO), peer-review organization (PRO), or educational/training institution?
9. Yes No Are you currently or have you ever been excluded, debarred, suspended or otherwise ineligible to participate in the Federal (Medicare & Medi-Cal) health care programs, i.e., are you considered an "ineligible person" for billing Federal health care programs?
10. Yes No Have you been charged or convicted of a criminal offense which will make you an "ineligible person" but you are not yet excluded from participating in Federal health care programs?
11. Yes No Have you ever participated in a managed care plan in which you no longer participate?
12. Yes No Have you ever been convicted, suspended or assessed a civil penalty under the anti-fraud and abuse provision of the Medicare or Medicaid program?
13. Yes No Are you currently under investigation by the Medicare and/or Medicaid programs?
14. Yes No Have Medicare or Medicaid authorities ever investigated or brought charges against you?
15. Yes No Have any malpractice claims been filed against you during the past ten (10) years?
16. Yes No Have you ever been convicted of gross misconduct, a felony, misdemeanor, or a crime of moral turpitude?
17. Yes No Have you ever resigned from a health care facility while under investigation or to avoid possible disciplinary action?
18. Yes No Has any hospital as a result of reviewing your patient care or your performance, conducted a hearing or taken any action concerning your staff membership/privileges or required additional supervision?
19. Yes No Have any complaints been registered against you with your state licensing body, regulatory body, professional association, employer or healthcare facility at which you practice(d)?
20. Yes No Have you ever had a complaint, claim or suit brought against you for alleged sexual misconduct?
21. Yes No Have you ever provided any professional services without professional liability insurance?
22. Yes No Have you ever treated any patients by means of unconventional therapeutics, or utilized FDA experimental drugs other than through Institutional Review Board (IRB) approved research programs?

23. Yes No Does your practice currently include telemental health? If yes, can you show that your current professional liability insurance carrier specifically covers you for the practice of telemental health? _____ Yes _____ No

For ANY and ALL YES answers above, indicate the question number and then please provide a detailed explanation in the space provided below. Explanation should include dates, circumstances of the incident, final outcome, current disposition, etc.

Name and Title	Address	Contact phone/email
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

You can download our Professional Reference Form and give that to your references. Please provide them with the form and a stamped envelope addressed to: Dr. John Schaeffer, 3308 El Camino Ave, Suite 300-136, Sacramento, CA 95821. If you use this paper method, we will call the references if we have any questions, and so please do provide their contact information above. Check this line _____ if you are giving the form to your references to mail to us directly. Letters of reference mailed from the applicant are not sufficient.

M. ELECTRONIC SIGNATURE (move to section N if signing by hand).

Please read this statement before signing:

Information provided on this application may be verified, including but not limited to, by contacting former employers. By typing my name into this form, I certify that all the information provided on this Independent Contractor Application and any submitted supportive documentation is true, correct and complete. I understand and agree that any misstatements or omissions of material facts herein may cause forfeiture on my part of my right to participate as a provider California Telepsychiatrists or American Telepsychiatrists.

Applicant's Name _____ **Date** _____

N. SIGNATURE

Please read this statement before signing:

Information provided on this application may be verified, including but not limited to, by contacting former employers. By signing this form, I certify that all the information provided on this Independent Contractor Application and any submitted supportive documentation is true, correct and complete. I understand and agree that any misstatements or omissions of material facts herein may cause forfeiture on my part of my right to participate as a provider California Telepsychiatrists or American Telepsychiatrists.

Applicant's Signature _____ **Date** _____

CALIFORNIA TELEPSYCHIATRISTS & AMERICAN TELEPSYCHIATRISTS ARE BOTH AN EQUAL OPPORTUNITY, DISABILITIES, AFFIRMATIVE ACTION ORGANIZATION THAT DOES NOT DISCRIMINATE IN REGARDS TO AGE, GENDER, COLOR, RACE, RELIGION, NATIONAL ORIGIN, HANDICAP OR SEXUAL ORIENTATION.