

Professional Qualifications Questionnaire CE Medical & Psychiatric/Psychological Consultant

Please Print			
Full Legal Name			
DBA			
Type of Business Entity: <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> For Profit Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Other—Please Explain		Birth Date	
		Social Security No.	
		Federal Employer No.	
		State Tax ID No.	
Specialty		Sub-specialty	
For Physicians Only Board Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No		For Physician's Only Board Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Active Hawaii Medical/Psychological License <input type="checkbox"/> Yes <input type="checkbox"/> No		Hawaii License No.	
		Date License Obtained	
Medical/Graduate School Attended			Year of Graduation
What days and hours will you be available to provide services?			
Approximately how many exams will be able to perform?		Weekly	
		Monthly	
Geographic Area you are able to serve			

CE Professional Qualifications Questionnaire

If the answer to any of the following questions is a “yes,” please give full details on a separate sheet of paper.

1. Has your license to practice medicine/psychology in any jurisdiction ever been limited, suspended, or revoked?

Yes No

2. Have your privileges at any institution ever been suspended, diminished, revoked, or not renewed?

Yes No

3. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical/psychological organization?

Yes No

4. Have judgments or settlements been bade against you in professional liability cases, or are there any pending?

Yes No

5. Would your health status in any way affect your ability to perform consultations?

Yes No

6. Have you ever been excluded or otherwise barred from participation in the Medicare or Medicaid program, or any other Federal or Federally assisted programs?

Yes No

7. Do you have any objections to a credentials check with the Federation of State Medical Boards?

Yes No

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Please provide three references:

1.

Name	Title
Address	Telephone

2.

Name	Title
Address	Telephone

3.

Name	Title
Address	Telephone

Signature: _____ Date: _____

Phone: _____ Fax: _____

Email: _____

Street Address
(Where Exams will be performed)

Mailing Address
(If different)

Please attach a copy of your curriculum vitae and medical license.