

Please list any clinical services you do not perform that are typically associated with your specialty:

Is your practice limited to certain age groups? Yes No

If yes, specify limitations: _____

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? Yes No

Do you participate in EDI (electronic data interchange)? Yes No

If so, which Network? _____

Do you use practice management systems/software? Yes No

If 'Yes', which one _____

What type of anesthesia do you provide in your group/office?

Local Regional Conscious Sedation General None Other (specify)

Has your office received any of the following accreditations, certifications or licensures?

- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- California Department of Health Services Licensure
- Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
- Medicare Certification
- The Medical Quality Commission (TMQC)
- Other _____

IV. OFFICE HOURS- Please indicate the hours your office is open:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Holidays

V. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary)

Answering service company: _____ Phone Number () _____ Fax Number () _____

Mailing Address: _____ City: _____
 State: _____ ZIP: _____

Covering Physician's Name _____ Telephone Number: () _____

Covering Physician's Name _____ Telephone Number: () _____

Covering Physician's Name _____ Telephone Number: () _____

Covering Physician's Name _____ Telephone Number: () _____

If you do not have hospital privileges, please provide written plan for continuity of care:

VI. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:

Fluently by Staff:

VII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

Tax ID #:

Billing name:

Type of service provided:

Do you have a CLIA certificate?

Yes

No

Do you have a CLIA waiver?

Yes

No

Certificate number:

Certificate expiration date:

VIII. PROFESSIONAL ORGANIZATIONS

Please list county, state or national medical societies or other professional organizations or societies of which you are a member or applicant.

Organization Name	Applicant	Member
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

I certify that the information in this document and any attached documents is true and correct

Print Name Here _____

Physician Signature _____ Date _____
 (Stamped Signature Is Not Acceptable)