Qualivis

HEALTHCARE PRESENTATION

FACILITY NAME:	
POSITION SUBMITTING TO:	
PROVIDER'S FULL LEGAL NAME:	
PHONE NUMBER:	
EMAIL:	
INTERVIEW AVAILABILITY:	
DEGREE:	
NPI#:	
PROVIDER'S SPECIALTY:	
BOARD STATUS/BOARD SPECIALTY:	
ACTIVE CERTIFICATIONS:	
EXPERIENCE:	
STATE LICENSE STATUS:	
DEA STATUS:	
AVAILABLE START DATE:	
LENGTH OF AVAILABILITY:	
SHIFTS PER MONTH:	
SHIFTS AVAILABLE: (DAYS, NIGHTS, WEEKENDS)	
SCHEDULE RESTRICTIONS:	
BILL RATE:	
TRAVEL REQUIREMENTS:	

Qualivis PROVIDER QUESTIONNAIRE

Please answer "yes" or "no" to each question below. ***If your answer to any of questions is "YES," please provide full details below the section or on the last page of this questionnaire.***

For purposes of these questions, "health care entity" means an acute care hospital and/or its professional staff, as well as any other type of entity that provides or arranges for the provision of healthcare services, including a clinic or other outpatient facility, group medical practice, health maintenance organization, and/or the professional staff of any such entity; "clinical privileges" means any arrangement under which you are or were authorized to provide professional services; "affiliation" means membership, contract, employment, or any other type of professional relationship; "official" means an officer, department or committee chair, medical director, administrator, or any other individual having the authority to make recommendations or take action regarding clinical privileges; and "professional liability case/claim" includes, but is not limited to, any claim for professional negligence, medical errors or omissions, HIPAA breach, assault, or any other claim involving your professional practice.

LICENSURE

	Y/N
1. Have any disciplinary actions been threatened, initiated or are any pending against you by a state licensure board?	Y ○ N ○
2. Has your DEA registration or any state-controlled substance registration ever been relinquished, limited, denied, suspended, revoked or challenged?	Y ○ N ○
3. Has your license to practice in any state ever been denied, limited, suspended, revoked, diminished, not renewed, relinquished (whether voluntarily or involuntarily) or are any proceedings currently pending which may result in any such action?	Y ○ N ○
4. Have your privileges to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, not renewed, surrendered or have you been called before or warned with regard to these privileges by a state or any jurisdiction or federal agency at any time? Is any such action pending?	Y ○ N ○
5. Have any formal written complaints been filed against you with any state professional licensing board?	Y ○ N ○
If you answered Yes to any items in the **Licensure** section, please provide details below:	

AFFILIATIONS & PRIVILEGES

	Y/N
6. Have your clinical privileges ever been voluntarily or involuntarily limited, suspended, revoked, not renewed or subjected to probationary conditions or have proceedings toward any of those ends ever been instituted or recommended by any official committee or governing body of any healthcare entity?	Y ○ N ○
7. Has your medical staff membership, medical staff status, allied health status or any other type of affiliation at any health care entity ever been voluntarily or involuntarily limited, suspended, revoked, not renewed, denied or subjected to probationary conditions or have proceedings toward any of those ends ever been instituted or recommended by any official, committee or governing body of any healthcare entity?	Y ○ N ○
8. Has your request for any specific clinical privileges(s) ever been denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship) or has such a denial or limitation been recommended by any official, committee or governing body of any healthcare entity?	Y ○ N ○
9. Have you been denied clinical privileges or affiliation with any health care entity, or has such a denial ever been recommended by any official, committee or governing body of any healthcare entity?	Y ○ N ○
10. Have you been denied membership or renewal thereof or been subjected to any disciplinary action in any medical organization or professional society, local or state, including any professional review organization or have proceedings toward any of those ends ever been instituted?	Y ○ N ○
11. Have you voluntarily relinquished any membership or affiliation with any healthcare entity, clinical privileges, professional licenses or narcotics registration while under investigation, threat of investigation or disciplinary action?	Y ○ N ○

AFFILIATIONS & PRIVILEGES (CONTINUED)

	Y/N
12. Do you have any objections that your current affiliations or employer be contacted for verification purposes?	Y ○ N ○

If you answered Yes to any items in the **Affiliations & Privileges** section, please provide details below:

LIABILITY INSURANCE COVERAGE AND CLAIMS

	Y/N
13. Has your professional liability insurance coverage ever been terminated by action of an insurance company?	Y ○ N ○
14. Have you ever been denied professional liability coverage?	Y ○ N ○
15. Have judgments, settlements, or claims ever been made against you in any professional liability case?	Y ○ N ○
16. Have any professional liability suits been filed against you? Note: This includes any closed, dismissed, pending or open cases as well as arbitrations?	Y ○ N ○
17. Have you ever been the subject of an inquiry or disciplinary action by any governmental or other regulatory agency? Is any such action pending?	Y ○ N ○

If you answered Yes to any items in the **Liability Insurance Coverage and Claims** section, please provide details below. **If you answered Yes to question 16,** please identify 1st and 3rd party for each claim:

If the space above was not enough for all details in any section, please provide more information below:

By signing this questionnaire, I authorize Qualivis, LLC to initiate its qualifications process and to disclose and provide any facilities with which my application may be submitted and any agency through whom I was submitted to Qualivis, LLC with my medical or personnel records as appropriate, including any and all information contained on this questionnaire and supplemental documentation explaining any answers to this questionnaire, to complete this process.

During such time as my application is being processed, I agree to update this questionnaire should there be any change in the information provided. I hereby affirm that the information submitted in this questionnaire and any addenda thereto is current, correct, complete, and true to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application.

Provider Name **Date**