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Morton Grove, IL 60053
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STAFF PHYSICIAN PROFILE SUPPLEMENT (No. 7)

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A printed or typed response is required for all questions. This application must be signed by the physician. Please attach a curriculum vitae.

1. Name: _____
   (First) *(Middle Initial)* *(Last)*
2. Date of birth: _____
3. Home address: _____
   _____
4. Specialty: _____
5. Do you serve as: ☐ paid employee ☐ volunteer ☐ independent contractor
6. Do you maintain separate personal medical malpractice insurance coverage? ☐ Yes ☐ No **If "yes," please include a Certificate of Insurance.**
   Insurance Company Name: _____ Limits of Liability: _____
7. Does your policy cover you while performing work for this hospice/home health care agency? ☐ Yes ☐ No
8. Does the insurance include coverage for this hospice/home health care agency? ☐ Yes ☐ No
9. List all the states in which you are currently licensed:

State	License Number	Percentage of Practice

10. Has your license or medical staff privileges or appointment to a hospital ever been suspended, voluntarily withdrawn, reduced, withheld, denied, revoked or subjected to any disciplinary action? ☐ Yes ☐ No **If "yes," describe circumstances.** _____
    _____
11. Has any professional liability insurer ever canceled, declined or refused renewal of your professional liability insurance? ☐ Yes ☐ No
12. In the past ten years, has a professional liability claim or suit against you been filed or closed, or are you aware of any pending or potential claim or suit? ☐ Yes ☐ No

    IF "YES," PLEASE PROVIDE NARRATIVE DESCRIPTION OF MEDICAL FACTS AND COMPLETE THE FOLLOWING CHART FOR EACH INCIDENT. INCOMPLETE INFORMATION WILL DELAY THE PROCESSING OF THIS APPLICATION. (PLEASE NOTE THAT A HARD COPY LOSS RUN FROM YOUR PREVIOUS CARRIER(S) MAY BE REQUIRED.)

Plaintiff	Incident Date	Report Date	Status (Open or Closed)	Settlement Amount	Date Paid	Insurance Company

13. Have all known potential claims or suits, if any, been reported to your current insurance carrier? ☐ Yes ☐ No

STAFF PHYSICIAN / NURSE PRACTITIONER PROFILE SUPPLEMENT (No. 7)
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Please continue with the following questions if you are a Physician.

14. Licensed Specialty: _____
15. Do you participate in the State Patient Compensation Fund (PCF)? ☐ Yes ☐ No ☐ Not Applicable
    If "yes," please include the PCF Certificate of Insurance.
16. Are you board certified? ☐ Yes ☐ No
17. Name of certifying board: _____
18. Medical school: _____
19. If foreign-trained, are you ECFMG-certified? ☐ Yes ☐ No
20. Degree: _____ Date completed: _____
21. Residency: _____ Date completed: _____
22. Fellowship: _____ Date completed: _____
23. First practice date (post residency, fellowship or military service): (Mo/Yr.) _____
24. Have you participated in any continuing medical education within the last three years? ☐ Yes ☐ No
25. List all hospitals or facilities where you have admitting privileges: _____
    _____
26. Has your license to prescribe or dispense narcotics ever been refused, suspended or revoked? ☐ Yes ☐ No
    If "yes," attach a copy of the Medical Board Order.
27. Are you employed solely as a Medical Director of this organization? ☐ Yes ☐ No
28. Do your assigned duties entail clinical care while serving as Medical Director? ☐ Yes ☐ No

Note: A signature is required below for both Physicians and Nurse Practitioners.

_____ _____

Signature of Physician/Nurse Practitioner Date