

\_\_\_\_\_  
Address\_\_\_\_\_

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Country

### **Institutional Affiliations**

List in chronological order all **institutional** affiliations since completion of advanced practice education. Include all hospitals, corporations, military assignments, or government agencies. *Complete addresses must be included.* Attach an additional sheet if necessary.

Institution\_\_\_\_\_ Dates\_\_\_\_\_

Address\_\_\_\_\_

Type of Affiliation\_\_\_\_\_

Institution\_\_\_\_\_ Dates\_\_\_\_\_

Address\_\_\_\_\_

Type of Affiliation\_\_\_\_\_

Institution\_\_\_\_\_ Dates\_\_\_\_\_

Address\_\_\_\_\_

Type of Affiliation\_\_\_\_\_

### **Professional Liability**

#### **Insurance**

1. Have you ever been denied professional liability **insurance** coverage?

\_\_\_\_yes - n o

(If yes; state when and by *what* company?)

- 2 Has your present professional liability insurance carrier excluded any specific area of practice from your coverage?

- Y e s - n o

(If yes, list the excluded clinical activities and provide **a full** explanation on a **separate** sheet; include the name of the **carrier**, the **date(s)** and **specific information** concerning any **limitation**.)

3. Identify present carrier:

Carrier Name \_\_\_\_\_ Policy Number \_\_\_\_\_

Address \_\_\_\_\_

Coverage Period \_\_\_\_\_  
(from/to)

Legal Actions

1. Have any professional liability claims or suits ever been filed against you? - Y e s - n o
2. Have any professional Liability suits been filed against you that are presently pending? \_\_\_yes - n o
3. Have any judgments or settlements been made against you in professional liability Cases? \_\_\_yes - n o

If the answer to any of the above questions is yes, please provide a full explanation of the details of each matter on a separate sheet and attach. The explanation must include the name of the court in which the suit was filed, the caption and docket number of the case, the name and address of the attorney defending you, and all relevant details. Include suits in which a judgment or settlement was made against a professional corporation of which you **are/were** a member, shareholder, or employee in any matter in which you were involved in patient care.

Health Status

Do you have any physical or mental condition that affect your ability to exercise the duties of a Provider Affiliate for the Alabama Community Healthcare Network as outlined and described in you Provider Agreement? \_\_\_yes \_\_\_no

Will you require an accommodation to carry out those duties safely and competently? \_\_\_yes \_\_\_no

*If you answered in the affirmative , please arrange a confidential meeting with the Alabama Community Healthcare Network Executive Director immediately.*