RHODE ISLAND
PHYSICIANS CORPORATION
PRIMARY CARE

SERVICE ORGANIZATION APPLICATION

Please return application along with all of the **required information** to:
Membership Committee
Rhode Island Primary Care Physicians Corporation
1150 New London Avenue, Suite 20
Cranston, R.I. 02920
Questions call: 401.654.4000

Name: _____

Mailing Address: _____

Social Security Number: _____ Tax ID Number: _____

Email Adress: _____

Please Check - Would you like your email published on the RIPCPC public/external website: ____Yes ___No

	Specialty	Date of Certification	Date of Eligibility
1.	_____	_____	_____
2.	_____	_____	_____

Fellowship Training: (area of expertise): _____

I. PRACTICE INFORMATION

Type of practice: (check one) Solo_____ Group Practice____

Practice Name: _____ Number of Partner: _____

Hospital-Based _____ Hospital Name: _____

Please list your practice partner(s):

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Will any/all partner(s) be joining RIPCPC? _____

Practice Manager(s) Name: _____

Practice Location(s): Full Address	Phone Number(s)	Back Line	Fax Number
1.			
2.			
3.			

Please list the physician(s) who routinely provides coverage for you (other than members of you group practice):

Will you accept new patients into your practice?

Are there any limitations to your practice (patient types, etc.)?

What percentage of your practice is devoted to the speciality of ?

With which managed health care affiliations/organizations are you associated with?

Name Inclusive Dates

Name Inclusive Dates

Name Inclusive Dates

II. HOSPITAL AFFILIATIONS

Please list all staff appointments you currently hold:

Hospital	Type of Appointment (active, courtsey, consulting)	Date of Initial Appointment	Date of Expiration	%Practice Admissions

Do you have any limitations of privileges at any hospital at which you have been granted privileges?
If Yes, please detail limitations:

Please list other IPA of PHO affiliations:

III. LICENSURE

Please list the following information so that we may expedite future credentialing requirements from managed payors:

1. Lincense information:

	State	License #	Expiration Date
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
	Federal DEA #	_____	_____
	RI CMD #	_____	_____
	MA DEA #	_____	_____
	UPIN #	_____	_____

Profession Liability Carrier: _____

Policy Limits:_____ **Expiration Date:**_____

If you answer YES to any of the following questions, please provide a detailed explanation on a seperate sheet.

1. Have you ever had your state license refused, restricted, suspended or revoked in MA, RI or any other state? **YES**_____ **NO**_____

2. Has the Licensing Board of any state ever taken action against you? **YES**_____ **NO**_____

3. Has your license to prescribe narcotics ever been suspended, refused or revoked? **YES**_____ **NO**_____

4. Have your hospital privileges ever been suspended, restricted or revoked? **YES**_____ **NO**_____

5. Are you now or have you ever been involed in any malpractice suite, including arbitration? **YES**_____ **NO**_____

6. Have any malpractice judgements been entered against you? **YES**_____ **NO**_____

7. Has any malpractice claim settlement, not involving litigation or arbitration, ever been paid by you or on your behalf? **YES**_____ **NO**_____

8. Have you ever been the subject of investigation by a peer review committee? **YES**_____ **NO**_____

9. Have you ever been convicted of a crime? **YES**_____ **NO**_____

10. Have you ever been treated for alcoholism or drug addiction? **YES**_____ **NO**_____

11. Do you have any physical or mental disorders that may interfere with your obligation and duties as a physician? **YES**_____ **NO**_____

12. Have you ever been suspended from recieving payment under the medicare or medicaid program? **YES**_____ **NO**_____

13. Has your malpractice insurance ever been terminated or revoked except with your consent or at your request? **YES**_____ **NO**_____

14. Have you ever been denied membership or renewal in any medical organization? **YES**_____ **NO**_____

15. Have you ever been subject to disciplinary action in any medical organization? **YES**_____ **NO**_____

16. Have you ever voluntarily relinquished or not renewed privileges in a medical organization? **YES**_____ **NO**_____

17. Please list CME credits received during the past three Years:

Number of Hours

201_ _____

201_ _____

201_ _____

IV. DOCUMENTATION

Please attach copies of the following documents to this application prior to submitting:

____State Medical License ____Hospital Privileges*

____Professional Liabilty Insurance ____Board Certification

____Residency Completion ____DEA Registration

____State Controlled Substance Registration ____W-9

____Fellowship (if applicable) ____ CV

***Letter confirming Hopsital confirming privileges dated within 60 days of receipt of this application to RIPCPC**

V. REFERENCES

Please list at least two professional references that are current RIPCPC members, not including relatives.

Name_____ **Telephone**_____

Address_____

Name_____ **Telephone**_____

Address_____

RHODE ISLAND PRIMARY CARE PHYSICIANS CORPORATION reserves the right to request addiotional information for purposes of determining membership eligibilty.

I certifiy that the information provided is true and accurate to the best of my knowledge and understand that if Rhode Island Primay Care Physicians Corporation determines that this information is in any way incomplete, false of misleading, acceptance of this application will be considered void.

Signature:_____Date:_____

Print Name_____

APPLICATION CONSENT

In order to more completely evaluate my application for inclusion Rhode Island Primary Care Physicians Corporation (RIPCPC) and my continuing participation status with RIPCPC, I hereby give permission to RIPCPC to solict information regarding my professional credentials and qualifications. Specifically included in the consent, but not by way of limitation, is specific data on my quality of care and utilization statistics from chief(s) of Clinical Departments of hospitals or other health care facilities in which I have privileges, the National Data Bank, the State Board of professional regulations, the Department of Welfare, Medicaid and Medicare regulating agencies, drug enforcement agencies and colleagues.

I understand that RIPCPC will use this inoformation solely in confindence.

I hereby release from liability RIPCPC and its employee(s), Members, Directors or agents and any person(s) listed above who is approached for information concerning my medical qualifications.

Signature_____

Print Name_____

Date:_____