MICHIGAN ASSOCIATION OF HEALTH PLANS
Standard Practitioner Application

PLEASE:

1. **COMPLETE THIS ENTIRE APPLICATION.**
2. **SUBMIT A COPY TO THE HEALTH PLAN OF YOUR CHOICE AND RETAIN THE ORIGINAL FOR YOUR RECORDS.**
3. **CURRICULUM VITAE WILL NOT BE ACCEPTED AS REPLACEMENT FOR A PART OF THIS APPLICATION.**
4. **SIGN AND DATE: ATTESTATION ON PAGE 9 AND/OR 10.**
5. **SIGN AND DATE: RELEASE OF INFORMATION ON PAGE 11.**

I A. PERSONAL INFORMATION

1. _____ Name (Last, First, Middle)
2. _____ Degree/Professional Title
3. _____ Other Names You May Have Used (Maiden, a.k.a., etc.)
4. Gender: ☐ Male ☐ Female
5. _____ Home Address/Street
6. _____ City/State/Zip
7. (_____) _____ Home Telephone No.
8. (_____) _____ Home Fax No.
9. _____ E-mail Address
10. _____ Date of Birth (Month/Day/Year)
11. _____ Citizenship/Place of Birth
12. _____ Languages fluently spoken in addition to English
13. _____ Languages written in addition to English
14. _____ Social Security No.
15. _____ Ethnicity (Optional)
16. If you are not a US Citizen do you have authorization to work in the US? ☐ Yes ☐ No

I B. PRACTICE SPECIALTY FOR WHICH YOU ARE SEEKING AFFILIATION

1. Are you applying as a:

☐ **Primary Care Physician:**

- ☐ Family Practice
- ☐ Family Practice with Deliveries
- ☐ OB/Gyn
- ☐ Internal Medicine
- ☐ Internal Medicine/Pediatrics
- ☐ Other _____
- ☐ Pediatrics
- ☐ General Practice

☐ **Specialist:**

- ☐ Specialty _____
  - ☐ Sub-Specialty _____

☐ **Allied Health Practitioner:**

- ☐ Nurse Practitioner
- ☐ Clinical Nurse Specialist
- ☐ Optometrist
- ☐ Physician Assistant
- ☐ Nurse Midwife
- ☐ Other _____
- ☐ Psychologist
- ☐ Social Worker

2. Other medical interests in practice, research, etc: _____

COPY THIS PAGE FOR MORE THAN ONE OFFICE

II A. PRIMARY OFFICE PRACTICE INFORMATION:

Information will be published unless box checked: ☐

1. List the health plans this office location accepts: _____

_____

2. Type of Practice: ☐ Corporation ☐ Partnership ☐ Solo ☐ Institution
☐ Hospital Based ☐ Hospital Employed ☐ Rural/Federal Qualified Health Clinic

3. _____ Group Practice Name as Appears on SS4 or W-9 Form

4. _____ Federal Tax ID No.

5. _____ Address Suite City State County Zip

6. _____ Mailing address if different than above: newsletters, etc.

7. (_____) _____ Telephone No.

8. (_____) _____ Fax No.

9. _____ Office E-mail Address

10. (_____) _____ Emergency On-call No.

11. (_____) _____ Beeper No.

12. Internet access: ☐ Yes ☐ No

13. _____ Office Manager

14. (_____) _____ Telephone No.

15. (_____) _____ Fax No.

16. _____ Billing address where payments are to be sent Suite City State Zip

17. _____ Claims Payable to

18. _____ Languages other than English spoken by staff

19. Medicaid No. _____ Effective Date _____

20. Is office Handicap accessible: ☐ Yes ☐ No

21. List physicians practicing at this location: Specialty:

_____ _____

_____ _____

22. Office Hours:

	OFFICE HOURS			PRIMARY CARE APPOINTMENT HOURS AVAILABLE FOR PATIENT CARE	
	FROM	TO		FROM	TO
Monday			Monday		
Tuesday			Tuesday		
Wednesday			Wednesday		
Thursday			Thursday		
Friday			Friday		
Saturday			Saturday		
Sunday			Sunday		

23. Indicate the waiting time to obtain an appointment in your office for:
a. Routine visits _____ days b. Well exams _____ days c. Urgent problems _____ days

24.

Do you currently? (Check response)	Yes	No		Yes	No
Place an age limit on your patients? Minimum Age: ___ Maximum Age: ___			Accept Medicare Assignment?		
			Accept Medicaid Assignment?		
Accept new patients into practice?			Have 24-hour phone coverage?		
Accept new patients by physician referral only?			Have electronic medical record keeping system?		
Place limitation on patient gender? If "Yes", please specify limitation: ☐ Male ☐ Female			Have capability for electronic billing? Electronic Billing Code: _____		

25. Do you have an investment or other financial interest in any health care delivery organization? i.e. home health care, lab, managed care organization, etc. ☐ Yes ☐ No If yes, describe: _____

_____

26. List financial partners: _____

27. Have you "opted out" of Medicare? ☐ Yes ☐ No

28. List current accreditations, certifications or special recognitions: ☐ NCQA ☐ JCAHO ☐ URAC ☐ OTHER: _____

II B. CROSS COVERAGE [Please list covering practitioners. If additional information, please attach.]

1. Name of Practitioner _____ Specialty _____ (____) Telephone No. _____
   Address _____ Suite _____ City _____ State _____ Zip _____
   Hospital Affiliations _____
2. Name of Practitioner _____ Specialty _____ (____) Telephone No. _____
   Address _____ Suite _____ City _____ State _____ Zip _____
   Hospital Affiliations _____
3. Name of Practitioner _____ Specialty _____ (____) Telephone No. _____
   Address _____ Suite _____ City _____ State _____ Zip _____
   Hospital Affiliations _____

II C. 24-HOUR COVERAGE AND ADMITTING ARRANGEMENTS ☐ N/A

1. Do you have arrangements for 24-hour, 7-days-a-week medical coverage for your patients? ☐ Yes ☐ No
   If no, please explain: _____
2. Do you currently admit and care for your hospitalized patients? ☐ Yes ☐ No If no, please explain the formal inpatient coverage arrangement(s) for each inpatient facility: _____

II D. RADIOLOGY ☐ N/A

1. Do you perform/provide radiology services in your office? ☐ Yes ☐ No X-ray License No. _____
   If yes, at what site(s): _____
2. Do you perform mammograms? ☐ Yes ☐ No If yes, attach copy of State of Michigan and FDA certificate.

II E. DIAGNOSTICS ☐ N/A

1. If you provide direct laboratory services, please indicate the Tax ID No. utilized and provide CLIA or COLA information. Attach a copy of your CLIA or COLA certificate or waiver if you have one:
   Tax ID _____ Billing Name: CLIA / COLA _____ Type of Service Provided _____
2. Do you provide in-house Endoscopy procedures? ☐ Yes ☐ No

II F. SURGICAL ☐ N/A

1. If you have multiple office locations, which one(s) has a surgical suite(s): _____
   If yes, is it: (check all that apply) ☐ State licensed ☐ Medicare Certified ☐ ACR/FDA
   ☐ MQC Accredited ☐ AAAASF Accredited ☐ AAAHC Accredited
   ☐ Other _____
2. Other Certifications (e.g. Fluoroscopy, Radiography, etc.)
   Type _____ Number _____ Expiration _____
   Type _____ Number _____ Expiration _____

II G. ALLIED HEALTH PRACTITIONER SUPERVISING PHYSICIANS ☐ N/A

1. Name of Supervising Physician _____ Specialty _____ (____) Telephone No. _____
2. Address _____ Suite _____ City _____ State _____ Zip _____
3. Hospital Affiliations _____

III A. MEDICAL / PROFESSIONAL SCHOOL

List all Medical Schools/Institutions attended including undergraduate and graduate school for allied health practitioners. Enclose copies of your diplomas and certificates.

1. Medical/Professional School _____ Degree Awarded _____ Date of Graduation (mm/yy) _____
   Address _____ City _____ State _____ Zip _____
2. Medical/Professional School _____ Degree Awarded _____ Date of Graduation (mm/yy) _____
   Address _____ City _____ State _____ Zip _____

III B. POST GRADUATE TRAINING

List all training attended. Enclose copies of your certificates. Explain any 30-day or greater gap in your training on a separate sheet.

1. INTERNSHIP Program successfully completed? ☐ Yes ☐ No

Institution/Hospital _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
Address _____ City _____ State _____ Zip _____
Program Specialty _____ Program Director _____ (____) Telephone No. _____

2. RESIDENCY Program successfully completed? ☐ Yes ☐ No

Institution/Hospital _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
Address _____ City _____ State _____ Zip _____
Program Specialty _____ Program Director _____ (____) Telephone No. _____

3. FELLOWSHIP Program successfully completed? ☐ Yes ☐ No

Institution/Hospital _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
Address _____ City _____ State _____ Zip _____
Program Specialty _____ Program Director _____ (____) Telephone No. _____

4. OTHER _____

Program successfully completed? ☐ Yes ☐ No

Institution/Hospital _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
Address _____ City _____ State _____ Zip _____
Program Specialty _____ Program Director _____ (____) Telephone No. _____

Directions for Sections IV & V: List in chronological order (with the current affiliation first) all institutions where you have current affiliations and have had previous hospital privileges. This includes hospitals, residential treatment and rehabilitation centers, surgery centers, institutions, corporations, military assignments, or government agencies. Work history should include self-employment. If more space is needed, attach additional sheet(s). **A curriculum vitae (CV) is not sufficient as replacement for these sections.**

IV. HOSPITAL / FACILITY HISTORY

1. _____ _____ _____
CURRENT Primary Admitting Facility Dates From (mm/yy) Dates To (mm/yy)

_____
Address Suite City State Zip

_____ _____ _____ (_____) _____
Department/Specialty Staff Category Chairperson Telephone No.

2. _____ _____ _____
Admitting Facility Dates From (mm/yy) Dates To (mm/yy)

_____
Address Suite City State Zip

_____ _____ _____ (_____) _____
Department/Specialty Staff Category Chairperson Telephone No.

3. _____ _____ _____
Admitting Facility Dates From (mm/yy) Dates To (mm/yy)

_____
Address Suite City State Zip

_____ _____ _____ (_____) _____
Department/Specialty Staff Category Chairperson Telephone No.

4. _____ _____ _____
Admitting Facility Dates From (mm/yy) Dates To (mm/yy)

_____
Address Suite City State Zip

_____ _____ _____ (_____) _____
Department/Specialty Staff Category Chairperson Telephone No.

V. WORK HISTORY [Add additional sheets if more space required.]

Chronologically list all work history activities since completion of postgraduate training. Explain any gaps of more than thirty days.

1. _____ _____ _____ _____
Current Practice Contact Name Dates From (mm/yy) Dates To (mm/yy)

_____ (_____) _____
Address Suite City State Zip Telephone No.

2. _____ _____ _____ _____
Previous Practice/Employer Contact Name Dates From (mm/yy) Dates To (mm/yy)

_____ (_____) _____
Address Suite City State Zip Telephone No.

3. _____ _____ _____ _____
Previous Practice/Employer Contact Name Dates From (mm/yy) Dates To (mm/yy)

_____ (_____) _____
Address Suite City State Zip Telephone No.

VI. TIME INTERVALS [Explain any time intervals not accounted for in application.]

Suspended from Practice _____ From _____ To _____

Loss of License _____ From _____ To _____

Served in Military _____ From _____ To _____

Personal Leave _____ From _____ To _____

Other (Please describe) _____ From _____ To _____

VII. MEDICAL / PROFESSIONAL LICENSURE

1. _____ _____ _____
Michigan State Medical / Professional License No. Date First Issued Expiration Date

2. _____ _____
Michigan State Controlled Substance No. Expiration Date

3. _____ _____
Drug Enforcement Administration Certification No. (DEA) Expiration Date

4. ALL OTHER STATE MEDICAL/PROFESSIONAL LICENSES:

State: _____ License No.: _____ Expiration Date: _____

State: _____ License No.: _____ Expiration Date: _____

5. _____ 6. _____ or N/A ☐
Medicare ID No. ECFMG No.

7. _____ 8. _____ 9. _____
UPIN (Unique Physician Identification Number) NPI (National Provider Identifier) HIPAA Taxonomy Codes

VIII. BOARD CERTIFICATION/CERTIFYING ENTITY

Name of Board/Certifying Entity	Certificate No.	Date Certified / Re-certified	Expiration Date	Specialty
1.				
2.				
3.				

Have you applied for board certification other than those indicated above? ☐ Yes ☐ No

If yes, list board(s) and date(s): _____

If not certified, do you intend to apply? Yes ☐ Specify timeframe: _____

No ☐ Specify reason: _____

Have you ever taken and not passed a medical board examination? ☐ Yes ☐ No If yes, will you re-take? ☐ Yes ☐ No

IX. REFERENCES

List three professional references, preferably from your specialty area, not including relatives, and no more than one current partner or associate. NOTE: References must be from individuals who are directly familiar with your work, either clinical observation or close working relations.

1. _____ _____ (_____) _____
Name Title/Relationship Telephone No.

_____ (_____) _____
Address City State Zip Fax No

Email Address: _____

2. _____ _____ (_____) _____
Name Title/Relationship Telephone No.

_____ (_____) _____
Address City State Zip Fax No

Email Address: _____

3. _____ _____ (_____) _____
Name Title/Relationship Telephone No.

_____ (_____) _____
Address City State Zip Fax No

Email Address: _____

X. PROFESSIONAL LIABILITY CARRIER INFORMATION

Please list all of your professional liability carriers for the **past ten years**:

Does your current professional liability insurance cover you in all of your practice locations? ☐ Yes ☐ No

1. Current Insurance Carrier _____ Policy No. _____
   Address _____ City _____ State _____ Zip _____ (_____) Telephone No. _____
   Coverage Amount: (Claim/Aggregate) _____ Type of Coverage _____ Exclusions from Coverage _____
   Initial Date of Coverage _____ Retroactive Date of Coverage _____ Expiration Date _____

2. Current Insurance Carrier _____ Policy No. _____
   Address _____ City _____ State _____ Zip _____ (_____) Telephone No. _____
   Coverage Amount: (Claim/Aggregate) _____ Type of Coverage _____ Exclusions from Coverage _____
   Initial Date of Coverage _____ Retroactive Date of Coverage _____ Expiration Date _____

3. Current Insurance Carrier _____ Policy No. _____
   Address _____ City _____ State _____ Zip _____ (_____) Telephone No. _____
   Coverage Amount: (Claim/Aggregate) _____ Type of Coverage _____ Exclusions from Coverage _____
   Initial Date of Coverage _____ Retroactive Date of Coverage _____ Expiration Date _____

4. Current Insurance Carrier _____ Policy No. _____
   Address _____ City _____ State _____ Zip _____ (_____) Telephone No. _____
   Coverage Amount: (Claim/Aggregate) _____ Type of Coverage _____ Exclusions from Coverage _____
   Initial Date of Coverage _____ Retroactive Date of Coverage _____ Expiration Date _____

5. Current Insurance Carrier _____ Policy No. _____
   Address _____ City _____ State _____ Zip _____ (_____) Telephone No. _____
   Coverage Amount: (Claim/Aggregate) _____ Type of Coverage _____ Exclusions from Coverage _____
   Initial Date of Coverage _____ Retroactive Date of Coverage _____ Expiration Date _____

XI. CLAIM / LAWSUIT HISTORY - 10 YR. HISTORY

If you answer "YES" to any of the following questions, please provide details per the attached claims information sheet. Please explain any surcharge to your professional liability coverage on a separate sheet.	YES	NO
Have you ever been a defendant in a malpractice suit?		
Have any judgments been made against you or settlements been agreed to in any professional liability cases?		
Are there any professional liability lawsuits pending against you at the present time?		
Has your professional liability insurance ever been terminated or restricted or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?		

XII. HEALTH STATUS

If the answer to any question is "YES", reference the question on a separate sheet. Please provide a full explanation and attach.	YES	NO
Are you currently using any chemical substance(s), which in any way may impair or limit your ability to practice medicine with reasonable skill and safety?		
Are you currently engaged in the illegal use of controlled substances?		
Do you have a mental or physical condition, which in any way may impair or limit your ability to practice medicine with reasonable skill and safety with or without reasonable accommodation?		

XIII. PROFESSIONAL PRACTICE

Have any of the following been or are currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, reviewed, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other state, territory or country? If "YES", provide full explanation and attach.	YES	NO
Medical or professional license		
DEA Registration or Controlled Substance license		
Hospital medical staff membership		
Clinical privileges or other rights on any hospital medical staff		
Employment by any hospital, institution or the military		
Professional society membership		
Participation in any private, federal, or state health insurance program (i.e. Medicare, CHAMPUS, Medicaid)		
Participation in an HMO, PPO, or any other managed care organization		
Board Certification		

XIV. OTHER DISCLOSURES

At any time have you ever been:	YES	NO
Convicted of any criminal offense in any jurisdiction		
Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of trial, or an accelerated rehabilitation disposition of felony charges in any state, territory or country		
Have you ever, at any time, or are you currently:	**YES**	**NO**
Under audit by a Health Care Agency (i.e. Medicare, Medicaid, MDCH, or any insurance)		
Under indictment for any crime		
The subject of an investigation by any private, federal or state health insurance program or state, territory or country licensing board		
The subject of any adverse action reports to a state or federal agency		
Sanctioned by a government program or agency for any reason		
Have you ever, at any time, either voluntarily or involuntarily:	**YES**	**NO**
Withdrawn your application for medical staff membership at any facility		
Withdrawn your request for any clinical privileges at any facility		

XVII. ATTESTATION STATEMENT

I agree to the contents thereof as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that omission or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Signature: _____

Date: _____

Go To Next Page To Update Attestations

XVIII. UPDATE ATTESTATION STATEMENT

One signature block below is to be signed if a previously completed application is being reviewed and updated for submission to an additional organization.

The application was designed so that a practitioner need complete it in its entirety only once. If application is then made to another organization which accepts this Standard Application and it has been more than 60 days since the practitioner completed or updated the application, the practitioner may review the application, make any needed modifications and then sign one of the attestation statement blocks below, reconfirming that the application is complete, true and accurate. It is particularly important that the Disclosure Questions be reviewed and any changes made with appropriate documentation included.

I agree to the contents thereof as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that omission or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Signature: Date:

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Signature: Date:

I agree to the contents thereof as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that omission or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Signature: Date:

Michigan Association of Health Plans Standard Practitioner Application

CONSENT TO RELEASE OF INFORMATION FORM

I understand that this Consent to Release Information is made in connection with Physician/Practitioner contracting, credentialing, recredentialing or reappointment activity of the Plan. I further understand that the Plan is responsible for the evaluation of my professional training, experience, professional conduct and judgment. All information submitted by me or on my behalf pursuant to this Consent to Release Information is true and complete to the best of my knowledge and belief. I fully understand that any misstatement in or omission related thereto may constitute cause for the summary dismissal/denial of such participation in the Plan. I understand and agree that as an applicant for participation with the Plan, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I hereby authorize the Plan and its representative to contact and/or consult with any persons, entities or institutions (including, but not limited to, hospitals, HMOs, PPOs, other group practices and professional liability carriers) which I have been affiliated, have used for liability insurance or who may have information relevant to my character and professional competence and qualifications, whether or not such persons or institutions are listed as references by me. I consent to the release and communication of information and documents between the Plan and persons, entities or institutions in jurisdictions in which I have trained, resided, practiced, or applied for professional licensure, privileges or membership in plans for the purpose of evaluation of my professional training, experience, character, conduct, ethics and judgment, and to determine professional liability insurance and/or malpractice insurance claims history.

I also authorize and direct persons contacted by the Plan to provide such information regarding my character and/or professional competence and qualifications, my professional liability insurance and/or malpractice insurance claims history to representatives of the Plan and I understand in doing so, I am waiving my confidentiality rights to this information. I release and hold harmless from liability all persons, entities, or institutions who, in good faith and without malice for acts performed in gathering or exchanging information in this credentialing or recredentialing process. This release and hold harmless provision applies to all persons, entities and institutions who will provide and/or receive, as part of the Plan's credentialing or recredentialing process, information which may relate to my past or present physical and/or mental condition, including substance abuse, alcohol dependency and mental health information.

I further authorize the release of the above information or any other information obtained from the application by a credentialing verification organization (CVO) to any health care organization designated by me or one that has entered into an agreement with the CVO where I currently have, am currently applying, or in the future will be applying for participation. I also authorize the CVO or the Plan to allow my file to be reviewed by the organizations' state or national accrediting and licensing bodies.

I further affirm that I currently do not have any physical and/or mental conditions and/or impairments, such as substance abuse, alcohol dependency and/or mental health concerns which interfere with my ability to practice medicine. I agree to notify representatives of the Plan of any changes in my professional licensure, scope of hospital privileges, participating Plan status, status of my malpractice insurance, malpractice claims history information and practice locations. I understand that this application shall not be deemed complete until an on-site medical practice office review is completed, if applicable, as well as receipt of all information required by this application process. I further agree to appear before the Plan for interviews, if requested, or inquiries regarding evaluations of my professional qualifications at reasonable times and places.

A photocopy of this consent shall be as effective as an original when presented.

Practitioner's Printed Name: _____

Practitioner's Signature: _____ Date: _____

Updated Signature: _____ Date: _____

Updated Signature: _____ Date: _____

Updated Signature: _____ Date: _____

Updated Signature: _____ Date: _____

Updated Signature: _____ Date: _____

SUPPLEMENTAL CLAIMS INFORMATION FORM

N/A ☐ If no claims.

(PLEASE COMPLETE A SEPARATE FORM FOR EACH CLAIM)

Claim Number or Patient Initials: _____ Age: _____ Gender: _____

Incident Is: ☐ Pending Closed Date: _____

☐ Dismissed Date _____

☐ Settlement Date _____ $ _____

☐ Judgment Date _____ $ _____

You Are: ☐ Solo Defendant

☐ Co-Defendant With _____

☐ Other _____

Were the Settlement Terms Confidential? ☐ Yes ☐ No

Settlement/Judgment Details: _____

Amount Paid on Your Behalf: _____

Date of Incident: _____ Date Suit Filed: _____

Court: _____ Case No.: _____

Name and Address of Insurance Carrier at Time of Incident: _____

_____

Name of Additional Defendant(s): _____

_____

Explain in Detail the Plaintiff's Allegations: _____

_____

_____

Explain in Detail your Defenses to These Allegations: _____

_____

_____

Patient's Condition Post-Incident: _____

_____

_____

Whom may we consult for further legal information about the suit: _____

_____

_____

_____ _____

Signature of Applicant Date

_____

Print Name

Additional Documentation / Attachments

Please enclose the following copies with your application:

- ❑ Signed Authorization For Release of Information/Liability (Page 11)
- ❑ For updating of the MAHP application ONLY please sign Page 10 and 11
- ❑ Current Licensure
  - ❑ Michigan License to Practice
  - ❑ Michigan Drug Control License (if applicable)
  - ❑ Michigan Controlled Substance (if applicable)
  - ❑ Federal Controlled Substance Registration Certificate (DEA) (if applicable)
- ❑ Board Certification Certificate(s)
- ❑ Medical School, Internship, Residency, Fellowship certificates
- ❑ ECFMG Certificate for International Medical Graduates
- ❑ Current Professional Liability Coverage
- ❑ Completed Supplemental Claims Information Form indicating involvement in any suits or judgments (pending, settled or otherwise)
- ❑ CLIA/COLA Registration
- ❑ Mammography Certification (ACR & FDA)
- ❑ W-9
- ❑ Federal Tax Deposit Coupon
- ❑ Curriculum Vitae (with work history)
- ❑ X-ray License