

**RADIOLOGY CONSULTANTS OF NEW JERSEY, INC.  
(RADCON)**

302 Harper Drive, Suite 101, Moorestown, New Jersey 08057

**RADIOLOGY PROVIDER CREDENTIALING APPLICATION**

**YEAR** \_\_\_\_\_

Last Name: \_\_\_\_\_ Degree: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Other Names by which you have been known: \_\_\_\_\_

If you are not a US citizen, do you have authorization to work in the US? Yes \_\_\_ No \_\_\_

Group Name: \_\_\_\_\_

Primary Office Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Federal Tax ID of group: \_\_\_\_\_ Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SSN#: \_\_\_\_\_ NPI Enumerator: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male \_\_\_ Female \_\_\_

**EDUCATION:**

UNDERGRAD/  
PREMEDICAL  
EDUCATION College/Univ \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
Degree \_\_\_\_\_ Date of Grad \_\_\_\_\_

MEDICAL  
EDUCATION Medical School \_\_\_\_\_ Dates \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
Degree \_\_\_\_\_ Date of Grad \_\_\_\_\_

INTERNSHIP Hospital \_\_\_\_\_ Dates \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
Specialty \_\_\_\_\_ Date of Grad \_\_\_\_\_

RESIDENCY Hospital \_\_\_\_\_ Dates \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
Specialty \_\_\_\_\_ Date of Grad \_\_\_\_\_

FELLOWSHIP Hospital \_\_\_\_\_ Dates \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
Specialty \_\_\_\_\_ Date of Grad \_\_\_\_\_

**BOARD CERTIFICATION:**

American Board of: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Date Certified: \_\_\_\_\_

American Board of: \_\_\_\_\_  
Date Certified: \_\_\_\_\_

Are you pursuing Board Certification? Yes \_\_\_\_ No \_\_\_\_  
If yes, give details of plans to take Board exam: \_\_\_\_\_

New Jersey Medical License No.: \_\_\_\_\_ Issued: \_\_\_\_\_  
Expires: \_\_\_\_\_

Other State License: \_\_\_\_\_ No.: \_\_\_\_\_  
Issued: \_\_\_\_\_ Expires: \_\_\_\_\_

DEA License Number: \_\_\_\_\_ Expires: \_\_\_\_\_  
NJ CDS License Number: \_\_\_\_\_ Expires: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_

ECFMG Number (International Medical Graduates): \_\_\_\_\_

**ACADEMIC APPOINTMENTS:**

Institution: \_\_\_\_\_ Address: \_\_\_\_\_  
Title: \_\_\_\_\_ Dates: \_\_\_\_\_

**SOCIETIES AND SPECIALTY ORGANIZATIONS: Membership**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HOSPITAL STAFF AFFILIATIONS: (List current affiliations first)**

Hospital \_\_\_\_\_  
Street Address \_\_\_\_\_ Dates \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Hospital \_\_\_\_\_  
Street Address \_\_\_\_\_ Dates \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**WORK HISTORY:** (Leave no gaps since completion of training)

Note: Curriculum Vitae may be attached listing complete work history.

Employer: \_\_\_\_\_ Dates: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Dates: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**MALPRACTICE INSURANCE:**

*List insurers during the last five (5) years, with inclusive dates of coverage.*

Present Insurance Carrier \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy # \_\_\_\_\_ Dates of Coverage \_\_\_\_\_  
Coverage Amount: Individual \$ \_\_\_\_\_ Aggregate \$ \_\_\_\_\_

Previous Insurance Carrier \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy # \_\_\_\_\_ Dates of Coverage \_\_\_\_\_  
Coverage Amount: Individual \$ \_\_\_\_\_ Aggregate \$ \_\_\_\_\_

Previous Insurance Carrier \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy # \_\_\_\_\_ Dates of Coverage \_\_\_\_\_  
Coverage Amount: Individual \$ \_\_\_\_\_ Aggregate \$ \_\_\_\_\_

# CONFIDENTIAL

## Confidential Information:

YES NO

- \_\_\_ \_\_\_ 1. Have you had any of the following items denied, revoked, suspended, not renewed, placed under probation, subjected to disciplinary action or otherwise limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to the following items:
- \_\_\_ \_\_\_ License, DEA or CDS registration  
\_\_\_ \_\_\_ Hospital or other health care facility membership/privileges  
\_\_\_ \_\_\_ Professional organization membership  
\_\_\_ \_\_\_ Medicare, Medicaid, CHAMPUS or other governmental program participation  
\_\_\_ \_\_\_ HMO, PPO or other prepaid health plan participation

*If the answer to either of the above questions is yes, please explain in an attachment.*

- \_\_\_ \_\_\_ 2. Has your malpractice coverage been cancelled, restricted or limited at any time in the past?
- \_\_\_ \_\_\_ 3. Have you any inability, for any reason, to perform any of the mental and physical functions normally associated with practice in your specialty, with or without accommodation?
- \_\_\_ \_\_\_ 4. Has any malpractice claim settlement been paid by you or paid on your behalf in the last 5 years?
- \_\_\_ \_\_\_ 5. Have you ever been convicted of a felony, moral or ethical crime or experienced loss of license to practice?
- \_\_\_ \_\_\_ 6. Has your license to practice medicine in any state ever been revoked or have any restrictions or modifications ever been assessed against it?
- \_\_\_ \_\_\_ 7. Are you currently engaged in the unlawful use of drugs, including the use of prescription drugs without supervision of a licensed health care professional?
- \_\_\_ \_\_\_ 8. Have you been, or are you now being counseled and/or treated for alcohol or substance abuse?

If the answer to question number 4 is yes, please attach the following information for each lawsuit or settlement:

Date and details of the incident(s) leading to lawsuit or settlement

Date of lawsuit or settlement

Professional liability insurer involved

Your role in the incident(s)

Your status in any lawsuit or legal action (primary defendant, co-defendant, other)

Subsequent events, including patient outcome

Current status of lawsuit or other legal action

Amount reserved by carrier for each claim, or amount paid as an out-of-court settlement, or amount of jury award or court award (please obtain this information from your insurer if necessary)

**Please Enclose With Your Application:**

- \_\_\_ Copy of your current New Jersey Medical License.
- \_\_\_ Copy of your current DEA registration.
- \_\_\_ Copy of your current New Jersey CDS certificate.
- \_\_\_ Copy of your current professional liability insurance certificate of coverage.
- \_\_\_ Copy of your board certification (if applicable).
- \_\_\_ Copy of your curriculum vitae.
- \_\_\_ Copy of your proof of 150 hours of continuing medical education in a current 3-year period.

**NOTE: RADCON will accept only the following proof of CME: AMA Physician Recognition Award for CME, ACR CME Certificate or Medical Society of New Jersey CME Certificate.**

- \_\_\_ Brief synopsis of any malpractice cases within the past five years including date of occurrence and status of claim. Please use *Confidential Professional Liability Summary* at end of Application.
- \_\_\_ Signed statement permitting RADCON to obtain your malpractice history for the past five years from your professional liability carrier(s).

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

**AUTHORIZATION, ATTESTATION AND RELEASE**

In making application as a provider through Radiology Consultants of New Jersey, Inc., I have read and agree to abide by the Provider Agreement. Also,

I hereby signify my willingness to appear for interviews in regard to this application;

I authorize Radiology Consultants of New Jersey, Inc. to consult with members of medical staffs of hospitals with which I have been associated and with others who may have information bearing on my competence, character, and ethical qualifications;

I consent to Radiology Consultants of New Jersey, Inc. inspection of all records and documents that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges I request as well as my moral and ethical qualifications;

I release from liability all representatives of Radiology Consultants of New Jersey, Inc. for their acts performed in good faith and without malice in connection with evaluating my credentials;

I release from any liability all individuals and organizations, including previous and present professional liability carriers, who provide information in good faith and without malice concerning my competence, ethics, character, and other qualifications for Staff appointment and clinical privileges, including otherwise privileged or confidential information. I consent to disclosure to other hospitals, medical associations, and licensing boards, and to other similar organizations as required by law, any information regarding my professional standing or competence that the hospital, medical staff, or any individual may have, and release Radiology Consultants of New Jersey, Inc. from liability for so doing to the fullest extent permitted by law;

I pledge to provide continuous medical care of the highest quality and in the most cost efficient manner.

I hereby certify that the information contained in this application is complete, correct, and true. I understand and agree that I have the burden of producing adequate information for proper evaluation of this application. I further understand that any material misstatement in or omission from this application constitutes cause for denial of appointment or summary dismissal as a RADCON provider.

If any material changes occur affecting my professional status (malpractice settlement, loss of hospital staff privileges, loss of medical license or exclusion from participation in Medicare, etc.) it is my obligation to notify RADCON within 30 days.

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

(PLEASE PRINT NAME AS SIGNED ABOVE) \_\_\_\_\_

**CONFIDENTIAL PROFESSIONAL LIABILITY SUMMARY**

(NOTE) If there are no claims, please write N/A and sign and date this page)

Physician Name: \_\_\_\_\_

Please supply the following information for each malpractice action in which you are or have been involved in the past 5 years. All information will be kept confidential.

Date of occurrence of *alleged* malpractice: \_\_\_\_\_

Name of insurance carrier involved: \_\_\_\_\_

Your status is/was in this case: Primary Defendant: \_\_\_ Co-Defendant \_\_\_

Status of Case: Pending: \_\_\_ Settled out of Court \_\_\_ Found for Plaintiff \_\_\_ Found for Defendant \_\_\_

Dismissed/Dropped: \_\_\_ Settled: \_\_\_ If settled, please give amount \_\_\_\_\_

Professional relationship to patient: \_\_\_\_\_

*Alleged* harm to patient: \_\_\_\_\_

\_\_\_\_\_

What were you *alleged* to have done incorrectly or failed to have done correctly? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please provide any other details that you feel are pertinent to the case: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>SIGNATURE:</b> _____ <b>DATE:</b> _____
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