# 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:_____

Employer:_____Dates:_____
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 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: _____

_____

_____

**SIGNATURE:** _____ **DATE:**_____