MES SOLUTIONS SINCE 1978

Health Care Professional Credentialing

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Name:

Date: Date of Birth: / / Place of Birth:

Practice Name: Contact Person:

Office Address:

Phone: Fax: Email:

Payment Address:

Phone: Fax: Email:

Home Address:

Phone: Fax: Email:

Tax Payor ID #: NPI #:

Current practice composition: ________% Treatment ________% IME's

Medical License(s): **Please list all states in which you are licensed. If additional space is needed please indicate on a separate sheet.**

Certification: AADEP ABIME ABQAURP OTHER(please list):

Medical School: Year Graduated:

Board Certified: YES NO Specialty: Subspecialty: Expertise :
☐ ABMS ☐ AOA ☐ Other

Board Eligible: YES NO Specialty: Subspecialty:

Non-MD's / Allied Health Professionals: YES NO Specialty Certificate in: License Certification #:

Hospital Affiliations:

Teaching Appointments:

Do you speak any foreign languages? YES NO If yes, please list:

What are your testimony fees? Fees: ½ Day:_________ Full Day:_________

Malpractice Insurance Carrier: Policy Limits: Expires:

Have you been trained on the AMA Guides? ☐ YES ☐ NO If yes, what edition? ________ What date?_________

Please fax to: (832) 485.

1. Has your license to practice medicine in any jurisdiction ever been limited, suspended, or revoked?	☐ YES	☐ NO
2. Have your privileges at any hospital ever been suspended, restricted, reduced or revoked?	☐ YES	☐ NO
3. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action by any hospital or medical organization?	☐ YES	☐ NO
4. Have you been involved in any malpractice litigation?	☐ YES	☐ NO
5. Have you ever been convicted of a felony or a misdemeanor?	☐ YES	☐ NO
6. Has your narcotics license ever been suspended or revoked?	☐ YES	☐ NO
7. Are you or have you ever been addicted to or habitually used narcotics, alcohol, barbituates, or other mood altering drugs?	☐ YES	☐ NO
8. Have you ever been a patient in a hospital or sanitarium for treatment of an addictive, nervous or mental condition?	☐ YES	☐ NO
9. Are you engaged in active practice at least eight hours per week? *If yes, please indicate the number of hours:* _____ hrs.	☐ YES	☐ NO

If you answered yes to any of the questions,
please provide a brief explanation on a separate piece of paper.

Please sign and return this credentialing form along with the other documents included in the credentialing packet.

I certify that the above information is true and correct to the best of my knowledge. I agree to notify MES National Network Development immediately of any change in my licensure status(e.g. restrictions or revocations) or change in hospital privileges. I agree to notify MES National Network Development of any felonies, misdemeanors, or malpractice lawsuits that occur in the future.

Printed Name: ____

Health Care Professional Signature:____

Date:_____________________

Many national clients require that treating providers not derive greater than 25% of their annual income from the performance of IME's.
Hartford is one such client. Please call: **800.632.0596** if you do not meet that requirement and your file will be documented, accordingly.

Please fax to: (832) 485.