# Lexington Clinic Initial Credentialing/Privileging Packet Instructions

**Payer Applications**

- Answer disclosure questions on page 1 and sign.
- On page 2, enter name and medical license number and sign as highlighted.
- Enter highlighted demographic information on page 3.
- Enter licensure information as highlighted on page 4.
- Sign pages 5-6 **(we will notarize the forms here once received).**
- Enter highlighted information on page 7 and sign.
- Enter highlighted information on page 8 and sign.
- Answer disclosure questions on pages 9-12 and attached detailed explanations if required.

# Credentialing Application
# Part 3

| | YES | NO |
|---|---|---|
| Has your DEA license ever been limited or suspended? | ____ | ____ |
| Has your medical license every been limited or suspended? | ____ | ____ |
| Have you ever been censored or excluded by any third party or payor including Medicaid or Medicare? | ____ | ____ |
| Have you ever been refused hospital privileges or have your hospital privileges ever been limited, suspended or revoked? | ____ | ____ |
| Do you have any impairments or conditions which make you unable To perform the essential functions in your area of practice, without a direct threat to health an safety of others? | ____ | ____ |
| Are you currently using illegal drugs? | ____ | ____ |
| Have you had any malpractice claims during the past five (5) years? If so, give details in writing, **including amount of judgments/settlements**? | ____ | ____ |
| To your knowledge, have you ever been reported to the National Practitioner Data Bank? | ____ | ____ |
| Do you, or any family member own, or have an interest, in any diagnostic testing center, clinical laboratory, radiology service or surgery center, durable medical equipment company, or other health related service entity? | ____ | ____ |
| Have you, or are you presently, been indicted and/or convicted of a felony? | ____ | ____ |

**If the answer to any of the above questions is yes, please give detail in writing.**

**To the best of my knowledge, the answers to the above statements and questions are accurate. Should there be any change in the information, I agree to notify OMCA within two (2) weeks of the changes.**

**I further understand, that falsification of the above information could result in automatic termination of my Preferred Provider status with OMCA. I hereby authorize any third party which has information about my qualifications as a physician, to release such information to OMCA upon request.**

_______________________________ _______________________

Physician Signature Date

OMCA
OCCUPATIONAL MANAGED
— CARE ALLIANCE, INC. —

State Volunteer Mutual Insurance Company
P.O. Box 1065 - Brentwood, Tennessee 37027
Phone 615.377.1999 - WATS 800.342.2239 - FAX 615.370.1343

# AUTHORIZATION AND RELEASE FORM

From: ______________________ Medical License # ______________

RELEASE OF INFORMATION TO : Credentialing Coordinator
ProviderNet / Fairs Group/ OMCA
2211 Green Way
Louisville, KY 40220
Fax

State Volunteer Mutual Insurance Company ("SVMIC") is the carrier of my medical professional Liability insurance, and as such SVMIC maintains certain information regarding my medical practice, and specifically the history of any malpractice claims against me. I understand that this information is extremely sensitive and confidential. I acknowledge that SVMIC is protective of this information and will only release it upon my express and unambiguous consent and direction. I have decided, for reasons related to my practice, that certain information from SVMIC be provided as requested. I authorize SVMIC to provide to the above person or organization information relating to reports of any medical professional liability claims activity against me on record with SVMIC, but specifically limited to: 1) claims that have resulted in paid losses (settlements), and/ or 2) lawsuits (open or closed).

I HEREBY RELEASE SVMIC, ITS OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS FROM ANY CLAIMS, LIABILITIES, ACTIONS, DAMAGES, OR OTHERWISE, FOR THE RELEASE OF SUCH INFORMATION IF SUCH RELEASED INFORMATION IS DELIVERD IN GOOD FAITH AND WITHOUT MALICE. I ALSO ACKNOWLEDGE THAT MISTAKES MAY OCCUR IN THE PROVISION OF SUCH INFORMATION, AND, WITHOUT LIMITING THE FORGOING, I SPECIFICALLY RELEASE SVMIC, ITS OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS FROM ANY CLAIMS DUE TO INCORRECT, MISDELIVERED, OR OTHERWISE INAPPLICABLE INFORMATION IF SUCH ERRORS OCCURRED IN GOOD FAITH, AND UPON DISCOVERY, SVMIC TAKES REASONABLE CORRECTIVE ACTIONS.

*THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL SPECIFICALLY REVOKED BY ME IN WRITING.*

______________________________ DATE: ______________
Signature of Practitioner/ Health Care Provider

______________________________
PRINT NAME

Policy # ____________

* * Extender Employees - Provide Name of Policyholder ______________________

# TRICARE Non-Network Physician/Dentist Individual Application

First Name: ____________________ MI: ___ Last Name: ____________________

Gen: _________ Title: ______________________________________________

Social Security Number: ________________ NPI# ______________________

Physical Address (Street Address):

______________________________

______________________________

______________________________

Billing Address (If Different):

______________________________

______________________________

______________________________

Telephone No: ____________________

Fax Number: ____________________

Telephone No: ____________________

Email Address: ____________________

** Please attach a list of additional office locations.

Do you maintain a solo practice? ☐ Yes ☐ No

If yes, Tax ID # of solo practice: ____________________

NPI# ____________________________

Date you began using this Tax ID #: ___________

Do you work with an established group practice or institution? ☐ Yes ☐ No

If yes, practice name: _________________________

Practice Tax ID #: ____________________________

NPI# ________________________

Date you began practicing with this group number: ___________


PGBA, LLC
Provider Data Management
P.O. Box 870156
Surfside Beach, SC 29587-9756
1-877-TRICARE (1-877-874-2273)
Fax 1-888-279-3540
www.myTRICARE.com by PGBA


Revised: 1/20/2015


TRICARE is a registered trademark of the Department of Defense, Defense Health Agency. All rights reserved.

Do you sign your own claim forms? ☐ Yes ☐ No
If no, Signature Authorization forms are attached. Please complete these forms and have them notarized.

1. Speciality: ______________________________

2. License Number: ______________________________________________________________

Original License Date: _______________ Current Expiration Date: _______________

Attach a copy of your current state license.

3. Are you:

Employed by the US Government ☐ Yes ☐ No

Resident ☐ Yes ☐ No

If Yes, name of facility where you are completing your residency:

_____________________________________________________

PGBA, LLC
Provider Data Management
P.O. Box 870156
Surfside Beach, SC 29587-9756
1-877-TRICARE (1-877-874-2273)
Fax 1-888-279-3540
www.myTRICARE.com by PGBA

Revised: 1/20/2015

TRICARE is a registered trademark of the Department of Defense, Defense Health Agency. All rights reserved.

## PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

STATE OF ____________________________

COUNTY OF ___________________________

____________________________ being first duly sworn, deposes and says: I hereby authorize PGBA, LLC / Health Net Federal Services in the state of South Carolina to accept my facsimile or stamp signature shown below

(Facsimile, stamp or computer-generated signature as it will appear on the claim form)

as my true signature for all purposes under TRICARE in the same manner as if it were my actual signature, including my agreeing to abide by the TRICARE payment system concept and the remainder of the certification normally signed by the source of care as it appears on all TRICARE claim forms.

_________________________________
SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS ___ DAY OF ____ 20 ____

________________________________________
NOTARY PUBLIC IN AND FOR

COUNTY OF _______________________ STATE OF _________________________

(SEAL)

MY COMMISSION EXPIRES: ____________________

PGBA, LLC
Provider Data Management
P.O. Box 870156
Surfside Beach, SC 29587-9756
1-877-TRICARE (1-877-874-2273)
Fax 1-888-279-3540
www.myTRICARE.com by PGBA

Revised: 1/20/2015

TRICARE is a registered trademark of the Department of Defense, Defense Health Agency. All rights reserved.

# PROVIDER'S NOTARIZED SIGNATURE AUTHORIZATION

STATE OF ______________________

COUNTY OF ______________________

Know all persons by these presents:
That I, ________________________ have made, constituted and appointed and by these presents do make, constitute and appoint ____________________ my true and lawful attorney-in-fact for me and in my name, place and stead to sign my name on claims for payment for services provided by me submitted to TRICARE. My signature by my said attorney-in-fact includes my agreement to abide by the TRICARE payment system concept and the remainder of the certification appearing on all TRICARE claim forms. I hereby ratify and confirm all that my said attorney-in-fact shall lawfully do or cause to be done by virtue of the power granted herein.

In witness whereof I have hereunto set my hand this _______day of _______ 20______.

______________________________
SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS ____ DAY OF ____ 20____

__________________________________
NOTARY PUBLIC IN AND FOR

COUNTY OF ___________________ STATE OF____________________

(SEAL)

MY COMMISSION EXPIRES ________________________

PGBA, LLC
Provider Data Management
P.O. Box 870156
Surfside Beach, SC 29587-9756
1-877-TRICARE (1-877-874-2273)
Fax 1-888-279-3540
www.myTRICARE.com by PGBA

Revised: 1/20/2015

TRICARE is a registered trademark of the Department of Defense, Defense Health Agency. All rights reserved.

**To:** **Coventry Worker's Compensation**
**Credentialing/Provider Enrollment Department**

**Re:** **Please add the provider below to New Lexington Clinic, P.S.C., for Coventry Worker's Compensation (please see attached for additional provider information)**.

From: Shelia Gaddie
Provider Enrollment
New Lexington Clinic, P.S.C.
Phone: 859-258-6215
Fax 859-258-6203
Email: sgadd@lexclin.com

Provider:
NPI:
Address: 1221 South Broadway
Lexington, KY 40504

Phone: 859-258-4000
Fax:
Email:
Effective Date: 04/17/2023
Tax ID 61-1262927
Pay to Name: New Lexington Clinic, P.S.C.

Pay to Address:
New Lexington Clinic, P.S.C.
PO Box 17835
Belfast, ME 04915-4073
Phone: 859-258-6200
Fax: 859-258-6203

---

Printed Name Signature Date

**KY Department for Medicaid Services**
**Division of Program Integrity / Provider Licensing and Certification**

**KY Medicaid Partner Portal Application - Authorized Delegate Form**

I, _________________________, understand and acknowledge that I am legally responsible for my Kentucky Medicaid Provider Number and to be in compliance with all applicable Medicaid Rules and Regulations as outlined in 42 USC Section 1320a-7b, KRS 205, 907 KAR 1:671, or 907 KAR 1:672. It is my responsibility to review on a routine basis my Kentucky Medicaid Provider file for accuracy, which will require a Kentucky Medicaid Partner Portal Application (KY MPPA) account.

I, _________________________, hereby authorize New Lexington Clinic, PSC (individual, group, entity), or their duly appointed designee, when completing Kentucky Department for Medicaid Services (KY DMS) Provider Enrollment information (new, revalidation, and maintenance information to be updated) and electronically submitting to KY DMS:

1. To act as a proxy agent for me in the preparation, signature, and submission of New Enrollment, Maintenance information, and Revalidations. This proxy includes creating a user account into the internet-based systems of the KKY DMS, Kentucky Medicaid Partner Portal Application (KY MPPA).
2. To release my signature electronically, or electronically sign, all KY MPPA applications and only KY MPPA applications necessary for enrollment and updates to required information for KY Medicaid Provider Licensing and Certification.

This proxy applies only to KY DMS Provider Licensing and Certification activities as outlined above.

Initial Submission: The initial submission of this form requires signature to be within 30 days of submission of a Maintenance, Revalidation or new Enrollment. The effective date of this delegation shall run until the next Revalidation date of my Kentucky Medicaid Provider information, on file with KY DMS Provider Licensing and Certification. This time period shall be no longer than 5 years from date of my enrollment, or until revoked by myself, the Provider, Owner, Officer or Board member, or at a time of a change of information that requires being updated with KY DMS, i.e., name change.

Revoking Delegation: To revoke this delegation, I acknowledge that I must go into (or create an account with) the Kentucky Online Gateway (KOG), and de-link the credentialing agent and/or Authorized Delegate, thereby prohibiting the credentialing agent and/or Authorized Delegate from performing updates to my KY Medicaid information.

| **Individual Provider**<br>(Complete this column if submitting with an Individual Provider Enrollment, Revalidation or Maintenance) | **Group or Entity**<br>(Complete this column if submitting with a Group or Entity Enrollment, Revalidation or Maintenance) |
|---|---|
| Provider Name Printed: | Owner/Officer or Board Member Name Printed: |
| Individual Provider NPI: | Group NPI: |
| Social Security Number: | Social Security Number: N/A to Group/Entity |
| Federal Tax Identification Number: N/A to an Individual Provider | Group Federal Tax Identification Number: |
| Individual Provider Signature: | Group Owner/Officer or Board Member Signature: |
| Date Signed: | Date Signed: |

## SECTION 3: FINAL ADVERSE LEGAL ACTIONS

This section captures information regarding final adverse legal actions, such as convictions, exclusions, license revocations and license suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

**NOTE:** To satisfy the reporting requirement, section 3 must be filled out in its entirety, **and** all applicable attachments must be included.

### A. CONVICTIONS (AS DEFINED IN 42 C.F.R. SECTION 1001.2) WITHIN THE PRECEDING 10 YEARS

1. Any federal or state felony conviction(s).
2. Any misdemeanor conviction, under federal or state law, related to: (a) the delivery of an item or service under Medicare or a state health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offence described in 42 C.F.R. section 1001.101 or 1001.201.
5. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

### B. EXCLUSIONS, REVOCATIONS OR SUSPENSIONS

1. Any current or past revocation or suspension of medical license.
2. Any current or past revocation or suspension of accreditation.
3. Any current or past suspension or exclusion imposed by the U.S. Department of Health and Human Service's Office of Inspector General (OIG).
4. Any current or past debarment from participation in any Federal Executive Branch procurement or non-procurement program.
5. Any other current or past Federal Sanctions.
6. Any Medicaid exclusion, revocation, or termination of any billing number.

### C. FINAL ADVERSE LEGAL ACTION HISTORY

1. Have you, under any current or former name, ever had a final adverse legal action **listed above** imposed against you?

   ☐ YES – continue below

   ☐ NO – skip to section 4

2. If yes, report each final adverse legal action, when it occurred, and the federal or state agency or the court/ administrative body that imposed the action.

| FINAL ADVERSE LEGAL ACTION | DATE | ACTION TAKEN BY |
|---|---|---|
| | | |
| | | |
| | | |

| **8. If any individuals listed in questions #6, #7, and #17 are related to each other as spouse, parent, child, or sibling (including step or adoptive relationships), provide the following information: (**Attach extra page if necessary.) ☐ ***Check here for N/A*** | | |
|---|---|---|
| Name(a): | SSN: | |
| Relationship: | FEIN: | |
| Name(b): | SSN: | |
| Relationship: | FEIN: | |
| **9. If this facility employs a management company, please provide following information:** ☐ ***Check here for N/A*** | | |
| Name: | | |
| Address: | | |
| City: | State: | Zip: |
| **10. List the name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.** ☐ ***Check here for N/A*** | | |
| Name: | Provider Number: | |
| Address: | | |
| City: | State: | Zip: |
| **11. List the names and addresses of all other Kentucky Medicaid providers with which your health service and/or facility engages in a significant business transaction and/or a series of transactions that during any one (1) fiscal year exceed the lesser of $25,000 or 5% of your total operating expense. (**Attach extra page if necessary.) ☐ ***Check here for N/A*** | | |
| Name: | | |
| Address: | | |
| City: | State: | Zip: |
| **12. Reserved for Future Use.** | | |
| | | |
| **13. List the name, SSN, and address of any immediate family member who is authorized under Kentucky Law or any other states' professional boards to prescribe drugs, medicine, medical devices, or medical equipment in accordance with KRS 205.8477.** ☐ ***Check here for N/A*** | | |
| Name (a): | Credential (M.D., etc.): | |
| Address: | DOB: | SSN: |
| City: | State: | Zip: |
| Name (b): | Credential (M.D., etc.): | |
| Address: | DOB: | SSN: |
| City: | State: | Zip: |
| **14. List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title XVIII (Medicare), or Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state, since the inception of those programs.** (Attach extra page if necessary.) **If individual or organization is associated with a KY Medicaid provider number(s), please indicate below.** (Attach extra page if necessary.) ☐ ***Check here for N/A*** | | |
| NAME (a)/KY Medicaid Provider Number(s): | | |
| NAME (b)/KY Medicaid Provider Numbers(s): | | |
| **15. List the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX, or XXI of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs.** (Attach extra page if necessary.) **If individual or organization is associated with a KY Medicaid provider number(s), indicate below.** (Attach extra page if necessary.) ☐ ***Check here for N/A*** | | |
| NAME (a)/KY Medicaid Provider Number(s): | | |
| NAME (b)/KY Medicaid Provider Number(s): | | |

## SECTION C: ATTESTATIONS

## (TO BE COMPLETED IF ENROLLING AS AN INDIVIDUAL PROVIDER. DO NOT COMPLETE IF ENROLLING AS A GROUP OR ENTITY.)

**Please answer all questions. For any "Yes" response, please attach an explanation.**

| **1. LICENSURE** | | |
|---|---|---|
| ☐YES ☐NO | **a.** | Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? |
| ☐YES ☐NO | **b.** | Has there been any challenge to your licensure, registration or certification? |
| **2. HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS** | | |
| ☐YES ☐NO | **a.** | Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? |
| ☐YES ☐NO | **b.** | Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? |
| ☐YES ☐NO | **c.** | Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? |
| **3. EDUCATION, TRAINING AND BOARD CERTIFICATION** | | |
| ☐YES ☐NO | **a.** | Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign |
| ☐YES ☐NO | **b.** | Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? |
| ☐YES ☐NO | **c.** | Have any of your board certifications or eligibility ever been revoked? |
| ☐YES ☐NO | **d.** | Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation |
| **4. DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION** | | |
| ☐YES ☐NO | **a.** | Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished? |
| **5. MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION** | | |
| ☐YES ☐NO | **a.** | Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs? |
| **6. OTHER SANCTIONS OR INVESTIGATIONS** | | |
| ☐YES ☐NO | **a.** | Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? |
| ☐YES ☐NO | **b.** | To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? |
| ☐YES ☐NO | **c.** | Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? |
| ☐YES ☐NO | **d.** | Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct? |
| ☐YES ☐NO | **e.** | Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency? |

| 7. PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY | | |
|---|---|---|
| ☐YES ☐NO | a. | Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? |
| ☐YES ☐NO | b | Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history? |
| **8. MALPRACTICE CLAIMS HISTORY** | | |
| ☐YES ☐NO | a. | Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? * If yes, provide information for each case. |
| **9. CRIMINAL/CIVIL HISTORY** | | |
| ☐YES ☐NO | a. | Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony? |
| ☐YES ☐NO | b. | In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? |
| ☐YES ☐NO | c. | Have you ever been court-martialed for actions related to your duties as a medical professional? |
| **10. ABILITY TO PERFORM JOB** | | |
| ☐YES ☐NO | a. | Are you currently engaged in the illegal use of drugs?<br>("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.) |
| ☐YES ☐NO | b. | Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? |
| ☐YES ☐NO | c. | Do you have any reason to believe that you would pose a risk to the safety or wellbeing of your patients? |
| ☐YES ☐NO | d. | Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation? |