University of Louisville Physicians
Practitioner Questionnaire

Please read and answer the following mandatory questions carefully. All "Yes" answers require a detailed explanation, dated and signed by the physician/practitioner. Please check "No" if Not Applicable (N/A) is the answer.

1.	Has your license to practice in any state been involuntarily relinquished, not renewed, denied, revoked, suspended, reduced, limited, placed on probation, disciplined, or formally reprimanded?	☐ Yes	☐ No
2.	Have your medical staff privileges, clinical privileges, and/or hospital membership been involuntarily relinquished, not renewed, denied, revoked, suspended, reduced, limited, placed on probation, disciplined, or formally reprimanded?	☐ Yes	☐ No
3.	Have you resigned from a hospital staff or medical institution while under investigation related to professional competence or conduct?	☐ Yes	☐ No
4.	Have you ever been disciplined or formally reprimanded during your internship, residency fellowship, or any other education program, or has your academic appointment ever been involuntarily relinquished, not renewed, denied, revoked, suspended, reduced, limited, placed on probation, disciplined, or formally reprimanded?	☐ Yes	☐ No
5.	Has Medicare, Medicaid or any PRO or PSRO authority initiated any investigations or actions against you (such as fines, sanctions or dismissal from the program) for any reason?	☐ Yes	☐ No
6.	Have there been any criminal charges brought against you, including any felony convictions? *(If "yes," provide complete details including court reports and final actions.)*	☐ Yes	☐ No
7.	Have you ever been the object of an administrative, civil or criminal complaint or investigation regarding sexual misconduct?	☐ Yes	☐ No
8.	Do you have a medical condition, physical disability, or emotional impairment which in any way impairs or limits your ability to perform the essential functions of your practice with or without accommodations?	☐ Yes	☐ No
9.	Are you currently engaged in illegal use of any legal or illegal substances?	☐ Yes	☐ No
10.	Have you completed, or are you now participating in an impaired physicians/practitioners program? *(If "yes," provide detailed explanation in an attachment.)*	☐ Yes	☐ No
11.	In the past ten (10) years, have there been or are there currently pending, any professional liability claims or suits, settlements, judgments or arbitration proceedings involving your professional medical practice? *(Important Note: Complete a claim history form for each claim/malpractice activity)*	☐ Yes	☐ No
12.	To your knowledge, has any information pertaining to you been reported to the National Practitioner Data Bank?	☐ Yes	☐ No
13.	Have you ever had professional liability insurance that has been involuntarily cancelled, declined, reduced, limited, or not renewed based on your individual liability history?	☐ Yes	☐ No
14.	Has your DEA or Controlled Substance Registration in any state been involuntarily relinquished, not renewed, denied, revoked, suspended, reduced, limited, placed on probation, disciplined, or formally reprimanded?	☐ Yes	☐ No
15.	Has your board certification or eligibility been involuntarily relinquished, not renewed, denied, revoked, suspended, reduced, limited, placed on probation, disciplined, or formally reprimanded?	☐ Yes	☐ No

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Professional Liability Claims History Form

Complete a separate form for each malpractice claim (please copy this page if additional sheets are needed).

MALPRACTICE CLAIM DETAILS
Name of malpractice insurance carrier involved:
Case Number (if known):
Patient Name (not required):
Date of occurrence/incident:
Date claim/suit filed/reported:
Claim status: ❑ Pending ❑ Closed - Date closed: _____
If closed, indicate method of closing: ❑ Dismissed ❑ Settled ❑ Judgment ❑ Other: _____
Amount of settlement or judgment (if applicable): $ _____
Allegation(s):
If allegation(s) is/are not known, please provide a brief history/overview of your involvement with the patient:
Relationship to the patient: ❑ PCP ❑ Admitting MD ❑ ER ❑ Resident ❑ Surgeon ❑ Other: _____

DATE: _____ PRACTITIONER SIGNATURE: _____

PRINTED NAME: _____