

Government of the District of Columbia

Department of Health
Health Professionals
Licensing Administration



D.C. Board of
Medicine
Physician Profile

Please correct and initial any provided information that is inaccurate by drawing a line through the incorrect item and printing in ink the correction above or next to the incorrect item. Please type or print (legibly) any information that is not provided.

Please check this box if you are interested in volunteering for medical response during a bioterrorism event or any other public health emergency (Optional).

1. General Information:

Initial License Date _____

License Expiration Date _____

Maiden Name (Optional): _____

Include maiden name in profile? (Check one) Yes No

NOTE: The information prepopulated above cannot be changed by the practitioner. If you have a name change, notify the Board in writing and include legal documentation that supports the change.

2. Emergency Contact Information:

Web Site (Optional): _____

Include website address in profile? (Check one) Yes No

E-mail Address (Optional): _____

Include email address in profile? (Check one) Yes No

NOTE: Please provide a non-emergency e-mail address if you wish to communicate with the Board of Medicine electronically in the future.

Fax Number: _____

Check this box if you do not have a fax number.

Security Verification (Optional): _____

NOTE: If you provided a non-emergency e-mail address above, for verification purpose, please provide mother maiden name. This will facilitate electronic retrieval of a forgotten password in the future.

Mother's maiden name: _____

3. Address of Record:

(Used to receive license renewals, notifications, and orders)

4. Do you have primary Practice Address?

Yes

No

Practice Name *(Optional)*

Address *(Line 1)*

Address *(Line 2)*

City

State

Zip code

Telephone

() _____

% Time spent at this location _____ %

Translating Services available? *(check one)* Yes No

If yes, please check type (s) of translating services that are available:

- | |
|---|
| <input type="checkbox"/> Hearing impaired |
| <input type="checkbox"/> Non-English languages spoken |

Non-English Languages Spoken *(attach additional sheets if necessary)*.

Non-English Languages Spoken by Practitioner. *(attach additional sheets if necessary)*.

Days patients seen at this location (i.e. M-W-,F) *(Optional)* _____

5. Do you have an Additional Practice Address?

Yes

No

(attach additional sheets if necessary)

Practice Name *(Optional)*

Address *(Line 1)*

Address *(Line 2)*

City

State

Zip code

Telephone

() _____

% Time spent at this location _____ %

Translating Services available? *(check one)* Yes No

If yes, please check type (s) of translating services that are available:

- | |
|---|
| <input type="checkbox"/> Hearing impaired |
| <input type="checkbox"/> Non-English languages spoken |

Non-English Languages Spoken (*attach additional sheets if necessary*).

Non-English Languages Spoken by Practitioner (*attach additional sheets if necessary*).

_____ Days patients seen at this location M-W, F):(*Optional*) _____

6. Education: Please select the U.S. or Canadian school **Osteopathic**, attended (*attach additional sheets if necessary*).

U.S. or Canadian School Attended _____
U.S. or Canadian School Year of completion _____

If you attended a **non-U.S.** (and territories) **non-Canadian** school, please enter the name of the school below:

Non-U.S. School Attended _____
Non-U.S. Year of completion Non-U.S. State or Province _____
Non-U.S. Country _____

7. Post Graduate: Please indicate the name of the postgraduate medical or osteopathic education program attended (*attach additional sheets if necessary*):

Specialty _____
Program Name _____
City _____ State/Province _____ Country _____
Years Attended _____
Internship Residency Fellowship

Specialty _____
Program Name _____
City _____ State/Province _____ Country _____
Years Attended _____
Internship Residency Fellowship

Specialty _____
Program Name _____
City _____ State/Province _____ Country _____
Years Attended _____
Internship Residency Fellowship

8. Board Certification: Are you currently Board certified or sub-certified as approved by American Board of Medical Specialties or the Bureau of Osteopathic Specialists of the American Osteopathic Association? Yes No

If yes, please indicate the initial year of certification/ certification, and the year of expiration (*attach additional sheets if necessary*).

Year of Certification _____ Year of Expiration _____

Year of Certification _____ Year of Expiration _____

Year of Certification _____ Year of Expiration _____

9. Self-Designated Practice Area: Please indicate designated areas of practice (attach additional sheets if necessary):

10. Active/Clinical Practice: Please indicate total number of years in practice following completion of graduate medical, osteopathic, or education:

Number of years in active/clinical practice inside U.S./Canada Territories: _____

Number of years in active/clinical practice outside U.S./Canada Territories: _____

11. Medicaid:

Do you participate in District of Columbia Medicaid program? (check one) Yes No

Are you accepting new District of Columbia Medicaid patients? (check one) Yes No

12. Medicare:

Are you a Medicare participating provider? (check one) Yes No

Are you a Medicare non-participating provider? (Optional) (check one) Yes No

Are you accepting new Medicare patients? (Optional) (check one) Yes No

13. Current District of Columbia Hospitals with Admitting Privileges:

Please indicate from all the District of Columbia hospital/facilities at which you have admitting privileges (attach additional sheets if necessary).

14. Current District of Columbia Hospital Affiliations: Please indicate from any other District of Columbia hospital privileges/affiliated (attached additional sheets if necessary).

15. Current Out-of-State Hospital Affiliations: Please list the hospital name, city, and state for all hospitals privileges/affiliations in all states other than the District of Columbia (attached additional sheets if necessary).

Hospital _____ City _____ State _____

Hospital _____ City _____ State _____

16. Do you wish to provide information on Insurance Plans/Managed Care Plans Accepted (Optional)? Yes No

If yes, please list up to 10 health insurance plans that you accept. Include the name of the insurance company and the name of the specific insurance plan or managed care plan for each entry(e.g., Blue Cross and Blue Shield"). Check the box to the right of each entry if you also are a participating provider of the plan.

	Name of Insurance or Managed Care Plan Accepted	I am a participating provider in this plan
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Please provide a contact telephone number that consumers can call for further information on Insurance Plans that you accept: (_____)_____.

17. US/Canada Academic Appointments: Please indicate U.S./Canada Territories academic appointments (*attach additional sheets if necessary*).

School _____ Years Service _____ to _____
 School _____ Years Service _____ to _____
 School _____ Years Service _____ to _____

18. Non-U.S./Canada Academic Appointments: Please list non-U.S./Canada Territories academic appointments. Provide the full name and country for the school (*attach additional sheets if necessary*):

School	Country	Years of Service
_____	_____	_____ to _____
_____	_____	_____ to _____
_____	_____	_____ to _____

19. Publications: Please list publications in peer-reviewed literature within the last five years (maximum) of ten articles, attach additional sheets if necessary):

Title _____
 Journal _____
 Volume _____
 Website _____
 Date _____

Title _____
 Journal _____
 Volume _____
 Website _____
 Date _____

Title _____
 Journal _____
 Volume _____
 Website _____
 Date _____

Title _____
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Journal _____
Volume _____
Website _____
Date _____

Title _____
Journal _____
Volume _____
Website _____
Date _____

20. Honors/Awards (Optional): If you wish to provide information on honors or awards received, please indicate in the space provided. You may also use this section to include board certifications that are not listed in the Board Certification section (attach additional sheets if necessary).

Name of Honor/Award _____
Received From _____
Year Received _____

Name of Honor/Award _____
Received From _____
Year Received _____

21. District of Columbia Board of Medicine Notices and Orders:

Have you been the subject of a District of Columbia Board of Medicine Public Order.

Yes: _____ No: _____

22. Actions 1: You are required to report the following actions:

- Final orders of any regulatory board of another jurisdiction that result in the denial, probation, revocation, suspension, or restriction of any license;

- Final orders of any health regulatory board of another jurisdiction that result in reprimand or censure;
- Voluntary surrender of a license while under investigation in a state other than District of Columbia;
- Any disciplinary action taken by a federal health institution or federal agency.

Do you have any reportable actions? (check one) Yes No

NOTE: If yes, please complete the sections below (attach additional sheets if necessary):

Date of Action: _____

Entity Taking action: _____

Action Taken: _____

Date of Action: _____

Entity Taking action: _____

Action Taken: _____

23. Actions 2: Have you ever had any action taken by healthcare institutions, other practitioners, insurance companies, health maintenance organizations or professional organizations that resulted in a suspension or revocation of privileges or the of employment? (*check one*) Yes No

NOTE: If yes, please complete the sections below (attach additional sheets if necessary):

Date of Action: _____

Entity Taking action: _____

Action Taken: _____

Date of Action: _____

Entity Taking action: _____

Action Taken: _____

24. Paid Claims: You are required to provide a complete listing of all paid claims for the last ten years. This should include paid claims not only in the District of Columbia, but in other states and countries as well. Print the city, use the two letter state abbreviation, and print the country if non-U.S. For each paid claim, you may submit a brief description of the case for consumers to view. The presentation of this text will be limited to 300 characters on the web site. Please provide this text on an additional sheet of paper.

Payment Year: _____
Total US Dollar Amount: _____
Code for the Specialty at the time of paid claim: _____
City/State and/or Country _____
Settlement: _____ Judgment: _____

Payment Year: _____
Total US Dollar Amount: _____
Code for the Specialty at the time of paid claim: _____
City/State and/or Country _____
Settlement: _____ Judgment: _____

Payment Year: _____
Total US Dollar Amount: _____
Code for the Specialty at the time of paid claim: _____
City/State and/or Country _____
Settlement: _____ Judgment: _____

25. Felony Conviction Information: Have you ever been convicted in a court of law of committing a felony? (*check one*)

- Yes
- No

NOTE: *If yes, please complete all of the sections below (attach additional sheets).*

Date of conviction MM/DD/YYYY __/__/____

Were you convicted in the U.S. of a federal or state offense? (*check one*)

1. Federal State:
2. State - **specify which state:** _____
3. No-I was convicted of an offense in a non-U.S. country

Please specify U.S. state or federal code section (alpha numeric designation) that defines offense committed (do not complete if offense was committed in non-U.S. country): _____

Please provide a written description of the type of offense that was committed:

Please specify the jurisdiction where conviction occurred:

City/State and/or Country (if non-U.S.): _____

Type of sentence received (check only one):

- 1) Incarceration followed by probation
- 2) Incarceration without probation
- 3) Active supervised probation only
- 4) Active unsupervised probation only

Date of sentencing MM/DD/YYYY __/__/____

Length of sentence:

- 1. Suspended sentence: Number of years _____ Number of months _____
- 2. Sentence served: Number of years _____ Number of Months _____

Attestation:

I certify that the information provided in this questionnaire is true, complete, and accurate to the best of my knowledge. I further understand that providing incomplete or false information may constitute unprofessional conduct and may subject me to disciplinary action by the District of Columbia Board of Medicine.

District Of Columbia Board of Medicine Regulation **17 DCMR 4609** requires that I update my information within thirty days of a change.

Print Name _____

Complete License number _____

Signature _____

Date _____

Thank you for completing your questionnaire. You do not need to return the Code Lists, By regulation, your information must be received by the Board within **30** days from the date of the initial request. Earlier submission will expedite the Practitioner Information Collection process and would be most appreciated.

Please mail your completed and signed questionnaire to:

District of Columbia Board of Medicine Practitioner Information

899 North Capitol Street, NE, First Floor
Washington, DC 20002

If you have any questions, please call at:
(202) 724-4900

To view or edit your public profile online, visit the consumer website:

www.hpla.doh.dc.gov