Please PRINT LEGIBLY so we can record your information accurately

New York State **Physician** Profile

PHYSICIAN SURVEY

1. Physician

Name and mailing address *(Write a preferred address if necessary. This address is for contact purposes and will not be made available to the public.)*

☐ I request this change and/or addition to the data provided.

INSTRUCTIONS

Complete this survey by filling in blanks as directed. Please type or print using blue or black ink.

If any preprinted information appears incomplete or incorrect, write in your changes or additions. Indicate that you have made changes or additions by putting a check mark in the corresponding blue box, like this one:

☐ I request this change and/or addition to the data provided.

If you have questions:
Call the Physician Help Desk 1-888-338-6998

Mail your completed survey to:
NYS Physician Profile
NYS Department of Health
PO Box 5007
New York, NY 10274-5007

2. Signature

ANY LICENSEE WHO FAILS TO TIMELY REPORT OR WHO KNOWINGLY PROVIDES INACCURATE INFORMATION SHALL BE GUILTY OF PROFESSIONAL MISCONDUCT PURSUANT TO SECTION 6530 OF THE EDUCATION LAW.

After you have completed the survey, please sign it here.

_____ _____
Physician Signature *Date*

Under the penalties of perjury, I declare and affirm that the statements made in this profile, including accompanying documents, are true, complete and correct.

3. Additional Contact Information

(This information is for contact purposes and will not be made available to the public.)

Phone number

Fax number

E-Mail

4. License to Practice Medicine

	Number	Date Conferred
New York		
National Provider ID		

4A. Primary Field of Practice

List the code of your primary field of practice.
(See Fields of Practice Codes insert.)

_____
Code

4B. Secondary Fields of Practice

List the codes of your secondary fields of practice.
(See Fields of Practice Codes insert.)

_____ _____ _____ _____
Code Code Code Code

5. HIV Services *(Optional)*

Do you provide HIV services and/or care for patients on ARV?
☐ **Yes** ☐ **No**

Do you accept referrals of new HIV patients?
☐ **Yes** ☐ **No**

Are you certified by AAHIVM and/or member of HIVMA?
☐ **Yes** ☐ **No**

6. Education and Certification

Medical School from which you received degree | **Year degree received**

☐ I request this change and/or addition to the data provided.

6A. Graduate Medical Education *(ACGME, AOA or RCPSC accredited programs only)*

	Training Period		Was this training program completed in full?* (*self-reported)	Specialty
	Start Date	End Date		
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

☐ I request this change and/or addition to the data provided.

6B. Board Certifications *(ABMS, AOA or RCPSC recognized boards only)*

☐ **I do not have any of the above board certifications**

Name of Board	Certification Date	Expiration Date *(if applicable)*

☐ I request this change and/or addition to the data provided.

6C. Subspecialty *(if any)*

	Certification Date	Expiration Date *(if applicable)*

☐ I request this change and/or addition to the data provided.

6D. Professional Membership(s) *(Optional)*

Refer to attached cover letter for the inclusion criteria.
Attach a separate sheet if necessary.

☐ I request this change and/or addition to the data provided.

7. Teaching

A. Have you served as a full-time, part-time or adjunct faculty member of a medical school within the past 10 years?

☐ **Yes** ☐ **No**

If yes, list the institutions and beginning and end dates of your appointments.
If an institution is in New York State, list the Medical School Code (See the Survey Codes insert)

	Institution	Start Date	End Date *(if applicable)*
1.			
2.			
3.			

B. Were you responsible for teaching/supervising residents during the past 10 years? ☐ **Yes** ☐ **No**

8. Hospital Privileges

Do you have hospital admitting privileges?

☐ **Yes** **If yes, please list the codes of the hospitals where you have privileges.** *(For NY Hospital Codes, see the Survey Codes insert. For out of state hospital privileges, please provide this information in Section 20 Physician Concise Statement)*

(code)	(code)	(code)	(code)	(code)	(code)	(code)	(code)	(code)	(code)

☐ **No** **I do not have any hospital privileges.**

9. Participation in State or Federal Health Insurance Programs

Indicate your participation in these programs (including through managed care programs; you may indicate specific health plans in Question 19 of this survey)

	Yes, at all practice locations	Yes, at some locations	No
Medicaid			
Medicare			
Child Health Plus			
Family Health Plus			
Others (Specify Below)			

10. Translation Services

Do you have translation services on site at your primary practice location on a regular basis?

☐ **Yes** ☐ **No** **If yes, for what languages? Please list the Language Codes** *(See Language Codes in the Survey Codes insert.) (Note: If you practice in more than one location, your primary location is where you practice most often regardless of whether it is in private or group practice.)*

(code)	(code)	(code)	(code)	(code)	(code)	(code)	(code)	(code)	(code)

11. Malpractice

Have there been any malpractice award payments made on your behalf during the past 10 years?

☐ **Yes** ☐ **No**

If yes, please provide below the information about your malpractice history per event:

- *the type of award (judgment, settlement or arbitration)*
- *the date payment was awarded or the date claim was closed*
- *the payment amount in settlement of action or claim*
- *zip code or county and state of the location where the event occurred*
- *name of your malpractice insurance carrier: please indicate if you are self-insured*

If we have provided pre-printed malpractice information you may find that we have included in your carrier's name, and phone number as well as the claim #. This information is provided to you as a way for you to ascertain any of the above elements if they are missing.

The detail involving the specific dollar amount of the insurer's payment in settlement of the malpractice action or claim, the claim number, and the name of the carrier will not be made public. If the facts as you see them here are not accurate, please note the correction on this form and contact the insurance carrier at the phone number provided. If the list is incomplete, you must provide the above detail for any missing malpractice event within the past 10 years in the space provided.

NOTE: Please note that if you have medical malpractice payments that have been awarded on your behalf you will receive a separate letter regarding how this medical malpractice history will be disclosed to the public. In that letter if you have two or fewer settlements in the past ten year period you will be given the opportunity to provide any additional factual information, including supporting documentation, that you believe pertinent in the Department's consideration of whether this settlement information is relevant to patient decision making and consequently, included in your profile. ***Do not supply any additional information or documentation related to your medical malpractice case at this time. Please supply the required facts only.***

For each event add information here:

Type: Claim Number: Date:

☐ **I request this change and/or addition to the data provided.**

Amount: $

Facility Name:

County and State Name: Zip Code: Carrier Phone Number:

Insurance Company:

12. Licensee Actions

A. New York Licensee Actions

Any action taken by the New York State Board of Professional Medical Conduct against your license within the past 10 years, except those that remain confidential pursuant to the law, must be available on your profile.

There is no record of any action taken against your license by the New York State Board of Professional Medical Conduct.

12. Licensee Actions, *continued*

B. Out-of-State Licensee Actions

Have any actions been taken against you, except those that remain confidential pursuant to law, as a result of professional misconduct proceedings by any other state or licensing entity within the pat 10 years?

☐ **Yes** ☐ **No**

If yes, list the state or licensing entity, date, action taken, and summary of misconduct. (see example, right.)

***Example For Illustration Purposes Only*:**
Date: 08/08/11
State: California
Action: License suspension for one year
Summary: Self-administering anabolic steroids without proper medical indication.

(Attach a separate sheet if necessary.)

Date:

State:

Action:

Summary:

☐ **I request this change and/or addition to the data provided.**

13. Current Limitations

Are there any current restrictions/limitations against you, except those that remain confidential pursuant to law, as a result of actions taken by the NYS Board of Professional Medical Conduct or any similar actions pursuant to any State, Province or County to a specified are, type, scope or condition of practice?

☐ **Yes** ☐ **No**

If yes, list the state, province or county, and describe the restrictions or limitations (Attach a separate sheet if necessary.)

State:

Description:

14 Hospital Privilege Restrictions

Within the past 10 years, has there been any loss or involuntary restriction of your hospital privileges or removal of your medical staff membership related to the quality of patient care you delivered and where procedural due process has been afforded, exhausted or waived?

☐ **Yes** ☐ **No**

If yes, write a summary of the action taken, the facility name, the state where the action was taken and the date of the loss or restriction.

Action Taken	Facility	State	Date

Have you failed to renew your professional privileges or resigned from medical staff membership in lieu of a pending disciplinary case against you related to the quality of patient care you delivered?

☐ **Yes** ☐ **No**

If yes, write a summary of the action taken, the facility name, and the state where the failure to renew or resignation occurred and the date or dates of failure to renew or resignation.

Action Taken	Facility	State	Date

15 Criminal Convictions

Have you been convicted of a crime (felony or misdemeanor) in any state, province or county within the past 10 years?

☐ **Yes** ☐ **No**

If yes, list the offense and date of conviction.

Offense	Conviction Date

OPTIONAL INFORMATION

Completing the final four sections is optional. These sections provide you the opportunity to present additional information about yourself to the public if you choose to do so.

16. Practice Location *(Optional)*

For each practice location, list practice name, complete address, phone number and accessibility. *(If more than one office, list in order of where you practice most often) (If you choose not to report the complete address, please list your county or borough.)*

List the name of the physicians in your practice group. *(attach a separate sheet of paper if necessary.)*

NOTE: This information could be important to patients in order to identify physicians located in specific locations.

Practice Name:
Address:
County/Borough:
Phone:
Accessible to persons with disabilities: ☐ **Yes** ☐ **No**
Physicians:

Practice Name:
Address:
County/Borough:
Phone:
Accessible to persons with disabilities: ☐ **Yes** ☐ **No**
Physicians:

Practice Name:
Address:
County/Borough:
Phone:
Accessible to persons with disabilities: ☐ **Yes** ☐ **No**
Physicians:

Practice Name:
Address:
County/Borough:
Phone:
Accessible to persons with disabilities: ☐ **Yes** ☐ **No**
Physicians:

17. Publications *(Optional)*

List articles or research papers you have published in peer-reviewed medical literature within the past 10 years. *(Include article name, journal name and year. Attach a separate sheet if necessary.)*

Article (100 character maximum)	Journal (100 character maximum)	Year

18. Professional and Community Service Activities *(Optional)*

List your professional or community service activities or awards achieved. *(attach a separate sheet if necessary.)*

Organization and Service Description

19. Health Plan Contracts or Other Affiliation *(Optional)*

With what health plans are you contracted or affiliated? *Check plans that apply.*

- ❒ ABC Health Plan, Inc; NY
- ❒ Aetna Health Inc.
- ❒ Affinity Health Plan
- ❒ AmeriChoice of NY, Inc.; NY
- ❒ AmeriHealth Health Plan, Inc.; Elmsford
- ❒ Atlantis Health Plan, Inc.; NY
- ❒ Buffalo Community Health, Inc.; Buffalo
- ❒ Capital District Physicians Health Plan; Albany
- ❒ CarePlus, LLC; NY
- ❒ CenterCare, Inc.; NY
- ❒ Cigna Healthcare of NY, Inc.; NY
- ❒ Community Choice Health Plan of Westchester, Inc.; Yonkers
- ❒ Community Premier Plus, Inc.; NY
- ❒ Elderplan, Inc.; Brooklyn
- ❒ Empire HealthChoice HMO
- ❒ Empire HealthChoice, Inc.; NY
- ❒ Excellus Health Plan, Inc.; Rochester
- ❒ Excellus Health Plan, Inc.; Syracuse
- ❒ Excellus Health Plan, Inc.; Utica
- ❒ Finger Lakes HMO (Excellus)
- ❒ GHI HMO Select, Inc.; Kingston
- ❒ Health Insurance Plan of Greater NY, Inc.; NY
- ❒ HealthFirst PHSP, Inc.; NY
- ❒ HealthNet
- ❒ HEALTHNOW NEW YORK; (Community Blue) Buffalo
- ❒ HEALTHNOW NEW YORK; Albany
- ❒ HealthPlus, Inc.; Brooklyn
- ❒ Horizon HealthCare of NY, Inc.; NY
- ❒ Independent Health Association, Inc.; Buffalo
- ❒ Independent Health Association, Inc.; Tarrytown
- ❒ MagnalHealth; Garden City
- ❒ Managed Health, Inc.; (HealthFirst, A+ Health Plan) NY
- ❒ MDNY Healthcare, Inc.; Melville
- ❒ MetroPlus Health Plan; NY
- ❒ MVP Health Plan; NY
- ❒ Neighborhood Health Providers, LLC; NY
- ❒ NYS Catholic Health Plan; (Fidelis Care NY, Better Health Plan)
- ❒ Oxford Health Plans of NY; NY
- ❒ Rochester Area HMO/Preferred Care; Rochester
- ❒ SCHC Total Care, Inc.; Syracuse
- ❒ St. Barnabas Community health Plan (Partners in Health)
- ❒ Suffolk County Department of Health Services; Hauppauge
- ❒ The NY Hospital Community Health Plan; NY
- ❒ UnitedHealthcare fo NY, Inc.; NY
- ❒ UnitedHealthcare of Upstate NY, Inc.; East Syracuse
- ❒ Univera Halth Care (Excellus)
- ❒ Upstate HMO (Excellus)
- ❒ Vytra Health Plans Long Island, Inc.; Melville
- ❒ Wellcare of NY, Inc.; Newburgh
- ❒ Westchester Prepaid Health Services Plan; Tarrytown
- ❒ Other _____

20. Physician Concise Statement *(Optional)*

If you would like to make a concise statement specific to the information that will be contained in your NYS Physician Profile, please enter it here. Only the statement you would like the public to see should be entered in this space. Please note that if medical malpractice payments have been made on your behalf within the past ten year period you will receive a separate mailing which will give you the opportunity to review and comment on how this information will be displayed to the public. You may want to add or modify your concise statement related to medical malpractice at a later time when you have completed your review.

Use this blank page to write any additional notes

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