ACCESS DENTAL

ASSOCIATE PROVIDER APPLICATION

Practice Name | Telephone Number

ASSOCIATE PROVIDER INFORMATION

Title ☐ D.D.S. ☐ D.M.D. Specialty: ☐ Endodontist ☐ Oral Surgeon ☐ Orthodontist ☐ Pedodontist ☐ Periodontist ☐ Prosthodontist

Last Name | First Name | Middle Initial | Gender ☐ Male ☐ Female

Date of Birth | Social Security # | License # | Rendering Provider NPI

Do you prescribe medications? ☐ NO ☐ YES | Dental School Name | Year Graduated

If yes, provide DEA #_____

SPECIALTY BOARD STATUS Are you Board Certified? ☐ NO ☐ YES If No, are you or have you been Board Eligible? ☐ NO ☐ YES

If Yes, Year of Board Certification_____ Expiration _____

PROFESSIONAL WORK HISTORY

Please list all present and previous dental work history within the past five (5) years. Please provide written explanation of any breaks in history greater than 6 months. Curriculum vitae accepted in lieu of completing the following table.

Hire Date (mm/yy)	Term Date (mm/yy)	Employer	Location Address	Reason for Leaving

PROFESSIONAL LIABILITY INSURANCE *(Required coverage minimum: $500,000 per incident, $1,000,000 aggregate)*

Carrier | Limits | Effective Date | Term Date

HOSPITAL ADMITTING PRIVILEGES: Do you have hospital privileges? ☐ NO ☐ YES *(please complete below)*

Hospital Name | Address | Phone

CONFIDENTIAL INFORMATION

For any "Yes" response in this section, please provide a brief explanatory statement with your completed form.

1. Within the past five years up to and including the present, have you been involved in any malpractice suit or arbitration, or has any settlement ever been paid by you or paid on your behalf? IF YES, please provide a narrative and status for each case. ☐ YES ☐ NO
2. Have you ever had any one of the following items denied, revoked, suspended, not renewed, placed on probation, subjected to disciplinary action, or otherwise limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items:
   - State license ☐ YES ☐ NO
   - DEA, CDS, or other applicable narcotic registration ☐ YES ☐ NO
   - Hospital or other health-care facility staff membership or privileges ☐ YES ☐ NO
   - Medicaid or other government program participation ☐ YES ☐ NO
   - HMO, PPO, or other managed care plan ☐ YES ☐ NO
   - Employment as a health-care provider by a military service, hospital, HMO, or other health-care organization ☐ YES ☐ NO
3. Do you have any condition that, with or without accommodation, would make you unable to perform the essential functions within your area of practice or unable to perform such essential functions without health and safety of patients? ☐ YES ☐ NO
4. Within the past five years up to and including the present, have you used illegal drugs or have you had a chemical dependency or substance abuse problem? ☐ YES ☐ NO
5. Have you ever been convicted of a crime (other than a traffic offense), or are you currently under indictment for an alleged crime? ☐ YES ☐ NO

REQUIRED SUBMISSIONS

Please attach legible COPIES of the following:

☐ State Dental License (wallet-size only) ☐ Specialty Board Certificate (if applicable)
☐ DEA Certificate (if applicable) ☐ General Anesthesia License (if applicable)

ATTESTATION

I, the undersigned, hereby certify that the information provided on this application is truthful, correct and complete in all respects, and I further understand that the intentional submission of false or misleading information or the withholding of relevant information is grounds for termination as a participating dentist with the dental plan. The undersigned hereby agrees to notify the dental plan of any changes in the above information.

_____ _____

Dentist's Signature *(no signature stamps)* | Date