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MALPRACTICE CLAIMS

Are there currently any malpractice claims against you or past claims that remain subject to appeal? Yes No

Have you been contacted by anyone indicating that a malpractice lawsuit is being considered against you? Yes No

Please summarize on an attached sheet the details of any malpractice claims currently pending and all malpractice claims made against you within the past ten (10) years. Include date of occurrence, nature of allegations and the disposition of the claim, such as terms of any settlement or court judgment.

DISCLOSURES

If you answer any of the following questions in the affirmative, please explain on an attached sheet.

Has your employment, medical staff appointment or clinical privileges ever been suspended, diminished, revoked, refused or limited at any hospital or other health care facility whether voluntarily or involuntarily, or are any such actions pending? Yes No

Have you ever been the subject of disciplinary proceedings at any hospital or health care facility, or are any such actions pending? Yes No

Has your professional license in any jurisdiction, throughout your career, ever been voluntarily or involuntarily suspended, limited, revoked, denied, surrendered or been subject to probationary conditions, or are any such actions pending? Yes No

Has your DEA license or state narcotics registration ever been voluntarily or involuntarily suspended, limited, revoked, denied, or restricted, or are any such actions pending? Yes No

Were you the subject of any disciplinary proceedings during your medical training? Yes No

Have you ever been denied membership or renewal or been the subject of disciplinary proceedings of any professional organization, medical society, licensing authority or medical board, or are any such actions pending? Yes No

Has your liability insurance coverage ever been restricted, limited, denied, or not renewed? Yes No

Has your liability insurance coverage ever been terminated? Yes No

Has Medicare, Medicaid or any other medical reimbursement plan ever voluntarily or involuntarily suspended, limited, revoked, denied, not renewed or terminated your participation, or are any such actions pending? Yes No

Have you ever been convicted of a felony? Yes No

Has any information pertaining to you ever been reported to the National Practitioner Data Bank? Yes No

Do you have any emotional or physical disabilities that may limit your ability to practice medicine? Yes No

Do you have a history or current practice of engaging in illegal drug use including controlled substances? Yes No

AFFIRMATION

I hereby authorize Travel Clinics of America, LLC to verify the information on my application and consult with any person or entity that has or could have information regarding my background, experience, or credentials. I hereby release Travel Clinics of America, LLC, its employees, officers, owners and agents, from any liability for act or omission related to verification or failure to verify any information contained in my application.

I hereby affirm that the information shown upon my application or attached hereto is accurate to the best of my knowledge. I understand that any willful misstatements, misrepresentations, or omissions may be cause for termination of my association with Travel Clinics of America, LLC. If the information contained in my application becomes materially incorrect or incomplete, I agree to inform Travel Clinics of America, LLC within thirty (30) days of such material change.

Signature:

Print Name:

Date:

Address:

PLEASE ATTACH:

- o Copy of Resume

SUBMIT via fax, email or mail

Fax: 440.484.5298

Email: calpert@TravelClinicsofAmerica.com

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