

FPN HEALTHCARE PROFESSIONAL APPLICATION INSTRUCTIONS

Thank you for your interest in becoming an FPN Preferred Provider. To ensure your application is forwarded to our Credentialing Review Board, please forward the items listed below with your completed application:

- _____ \$85.00 Application Processing Fee (make check payable to "Fortified Provider Network, Inc.")

- _____ One Signed Contract (keep one conformed copy for your files and return one copy to us)

- _____ Copy of current DEA License (if applicable)

- _____ Copy of current State License

- _____ Copy of current Malpractice Insurance (must show liability limits)

- _____ Copy of current Curriculum Vitae

- _____ Copy of Board Certification or Eligibility (if available)

Please send the requested information to:

FORTIFIED PROVIDER NETWORK, INC.
8096 N. 85th Way, Suite 103
Scottsdale, AZ 85258

Additionally, please contact us with any questions you may have by emailing us at FPN@fortifiedprovider.com or calling our offices at (480) 607-0222.

FPN HEALTHCARE PROFESSIONAL APPLICATION

 Last Name First Middle Professional Degree

 Social Security Number Office Hours

 Practice Name (if any) County

 Address of Primary Office and Suite No.* City/State/Zip

 Billing Address of Primary Office City/State/Zip

 Telephone Number Fax Number Email address

 Federal Tax ID Number Office Manager

 Primary Medical Specialty Secondary Tertiary

**Please attach a separate sheet for additional addresses*

Do you have hospital privileges Yes No

If no, please explain _____

List the full name of hospitals at which you presently are on staff or have privileges:

 Primary Hospital Affiliation Level of Privileges City/State

 Other Hospital Affiliation Level of Privileges City/State

 Other Hospital Affiliation Level of Privileges City/State

RELEASE STATEMENT

Have you ever been or are currently in the process of being denied, revoked, suspended, limited, not renewed, or subject to probationary conditions or limitations from any of the following:

1. Medical or Allied Professional License in *any* state ___Yes___No
2. Membership on any hospital or institution's staff ___Yes___No
3. Board of Medical Examiners or Medical Society ___Yes___No
4. Malpractice or Liability Insurance coverage ___Yes___No
5. DEA Registration ___Yes___No
6. Medicare, Medicaid or CLIA program participation ___Yes___No

Have you had any of the following:

1. Any malpractice claims, suits, settlements or arbitration proceedings in the past five (5) years? ___Yes___No
2. Any conviction of a felony? ___Yes___No
3. Any chemical dependency or substance abuse problems that you have been treated for, or are currently being treated for? ___Yes___No
4. Any chronic or recurring illness or a major physical or mental disability, treated or untreated, that may limit your ability to practice? ___Yes___No

****Please provide an attached short explanation for any question(s) answered "yes".***

I fully understand that any misstatements in or omissions from this Application will constitute cause for termination or denial from participation in the FPN network. I hereby affirm that the information furnished is true and complete to the best of my knowledge.

I authorize release of any information pertaining to my past and present credentials and qualifications. I also release FPN and all FPN representatives from any liability for their acts performed in good faith and without malice in evaluating my credentials and qualifications. Further, I release all individuals and organizations that provide information to FPN regarding my claims, settlements, judgments, suspensions, restrictions, education, professional competence, character and other qualifications.

Physician Signature _____ Date _____

Contact person for additional information (if other than physician)

Contact Name _____ Phone _____

****Please refer to the FPN Physician Application Instructions cover sheet for items that must accompany this Application for processing.***