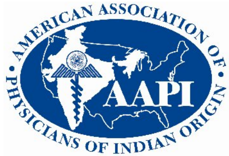


# American Association of Physicians of Indian Origin

**Executive Office:** 600 Enterprise Drive Suite 108, Oak Brook, IL 60523
Telephone: (630) 990-2277, Fax: (630) 990-2281
www.aapiusa.org
AAPI Tax ID: 38-2532505

## CONFIDENTIAL PHYSICIAN INFORMATION

Date____________________

NAME ________________________ _________________________ _______________________
Last First Middle

ADDRESS PHONE

Work ________________________________________ ________________________________

________________________________________ BEEPER

________________________________________ _________________________________

ADDRESS PHONE

Home ________________________________________ _________________________________

________________________________________

________________________________________

* **1. EDUCATION (or attach CV)**

| | School/Location | Graduation Date | Degree |
|---|---|---|---|
| Undergraduate | ________________________ | _____________ | _____________ |
| Medical/Dental | ________________________ | _____________ | _____________ |
| Postgraduate | __________________________ | _____________ | _____________ |
| Other | __________________________ | ______________ | ______________ |

## 2. TRAINING (or attach CV)

| Title | Institution/Location | Dates |
|---|---|---|
| ____________________ | ___________________________ | _______________ |
| ____________________ | ___________________________ | _______________ |
| ____________________ | ___________________________ | _______________ |

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## 3. WORK EXPERIENCE (Identify any additional work done on a voluntary basis)

| Position | Institution/Location | Dates |
|---|---|---|
| ____________________ | ____________________________ | _________________ |
| ____________________ | ____________________________ | _________________ |
| ___________________ | ____________________________ | _________________ |

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## 4. HOSPITAL OR HEALTH FACILITY STAFF APPOINTMENTS

List all hospital or facilities at which you are a member of the medical staff or have had any association, employment, privileges or practice for the past ten years.

| Name of Facility | Location | Department/Service | Staff Category | Dates |
|---|---|---|---|---|
| __________________ | ___________ | _________________ | ________________ | _________ |
| __________________ | ____________ | _________________ | _________________ | _________ |
| __________________ | ____________ | _________________ | __________________ | __________ |
| __________________ | ____________ | _________________ | __________________ | __________ |

## 5. TEACHING APPOINTMENTS

| Title | Institution | Location | Dates |
|---|---|---|---|
| _________________ | _________________ | ___________ | ____________ |

## * 6. BOARD CERTIFICATION

Are you Board Eligible? Yes________ (Specialty: ______________ ) No ________

Sub Specialty___________________

Certified by:

American Board of _______________________ Certificate Number _______________ Date _______

American Board of _______________________ Certificate Number________________ Date _______

*  **7. LICENSURE**

Primary Registration Number________________________ State______________ Expiration Date________________________

Other Licenses: State ____________________ Number _________________ Expiration Date ______________________

Other Licenses: State ____________________ Number_________________ Expiration Date ______________________

(Please a copy of your most recent Board of Registration in Medicine application for license and your license.

8. MEDICAL/PROFESSIONAL SOCIETY MEMBERSHIPS

AAPI______________________________ Member since________________________________________________________

ALUMNI _______________________________________________________________________________________

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9. Do you carry professional liability insurance: Yes__________ No_____________

If yes, carrier names and address: ________________________________________________________________

* Policy number: _______________________ Policy Limits: ________________________ Term: ____________

10. Citizenship of U.S. Yes_____________ No___________

If you are not an U.S. Citizen, have you the legal right to remain permanently in the U.S.?

Yes ____________ No_____________
(Please attach copy of Alien Registration Card - both sides)

11. Social Security Number ____________ - ___________ - ____________

*12. DEA No.________________________________________

13. Date of Birth ____________________________________

14. Marital Status: M _________ S __________ Name of Spouse _______________________

If you answer yes to questions 20-29, please submit an explanation as part of this application.

15. Has your license to practice medicine ever been suspended or revoked in any jurisdiction? Yes_____ No_______

16. Has your Control Substance Registration ever been suspended or revoked in any jurisdiction? Yes_____ No_______

17. Have your hospital privileges or membership on the medical staff of any hospital ever been suspended, diminished, revoked, not renewed or have you ever been subject to any hospital disciplinary action completed or ongoing? Yes_____ No_______

18. Have you ever been denied professional liability insurance? Yes_____ No_______

19. Have any formal or written claims alleging malpractice been made against you? Yes_____ No_______
(If yes, an explanation must include *name, address, age of claimant/plaintiff; *nature and substance of claim; *date and place at which claim arose; *date and manner of disposition and amount paid if any.)

20. Have any formal or written complaints been filed with the Board of Registration in Medicine or the equivalent board in any other state? Yes______ No_______

21. Have you ever been denied membership in, or a renewal of, or been subject to disciplinary proceedings in any medical/dental organization? Yes______ No_______

22. Have you ever been dependent on alcohol or drugs? Yes ______ No_______

23. Have you ever been convicted of a crime? Yes ______ No_______

24. Do you have any work related medical limitations? Yes______ No_______

25. Do you consent that AAPI can publicize the out come of your case in the AAPI Journal or other news media. Yes______ No_______

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I consent to the inspection of all pertinent records (excluding those of patients), to communications with any individual or hospital having information about me and to a personal interview if requested. I release from any liability all individuals and organizations that provide information to A.A.P.I. in good faith and without malice concerning my competence, ethics, character, and other qualifications for practicing medicine, including otherwise privileged or confidential information. I further release from any liability all individuals and organizations including A.A.P.I. and its members, employees or agents who receive information or written references from affiliated hospitals, medical organizations and or department of medicine/surgery.

________________________________ ________________________
(Signature of Applicant) (Date)

_________________________________ _________________________
Witness Date

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* Please submit copies of certificate or supportive documentation.

- Please submit a brief narrative report of your complaint on a separate sheet of paper. Please be succinct and accurate. Do not omit documents or names of persons that may impact your case. Please furnish addresses and e-mail addresses of all parties mentioned. Please submit this with the questionnaire.

- Briefly supply us with what actions that you have taken for your case.

- State what kind of help and support that you would like from the AAPI.

- Please submit a copy of your current hospital(s) bylaws with this questionnaire.