



PATIENT FREEDOM OF INFORMATION ACT

PROVIDER PROFILE REPORT FORM

Idaho Code §54-4603 requires that every applicant for licensure or registration and every currently licensed or registered Chiropractor, Dentist, Advanced Practice Professional Nurse (Nurse Practitioner, Certified Registered Nurse Anesthetist), Optometrist, Physician, Surgeon, Physicians' Assistant, Physical Therapist, Podiatrist, and Psychologist furnish the following information prior to the issuance or renewal of a license or registration: (Use additional pages, clearly labeled by section letter, if more space is necessary.) Provider information may be entered online at <http://www.idacare.org/update/userentry.cfm>.

LICENSEE

(profession & license #) _____
(name) _____
(business address) _____
(city, state, zip) _____
(e-mail address for board use only) _____

A. EDUCATION - Names and addresses of medical/professional schools or other institutions of higher learning that you attended, including any graduate education, and dates of graduation.

school name _____
address _____
city, state, zip _____
graduation date _____

school name _____
address _____
city, state, zip _____
graduation date _____

B. SPECIALTY CERTIFICATIONS - Specialty certifications that are recognized by the board

C. SPECIAL POSITIONS - Appointments to faculty of any medical/professional school and indication whether you have had a responsibility for graduate education within the most recent 10 years (optional)

D. LOCATION & PRACTICE HISTORY - Location & type of practice for the most recent 10 years, and the current location of your primary practice setting. If more than 1 setting, include the approximate percentage of time spent at each location.

current facility name _____
address _____
city, state, zip _____
type of practice _____
beginning & ending date _____

most recent past facility name _____
address _____
city, state, zip _____
type of practice _____
beginning & ending date _____

past facility name _____
address _____
city, state, zip _____
type of practice _____
beginning & ending date _____

- E. PRIMARY ADMITTING HOSPITAL - The hospital(s) that serves as your primary admitting facility and at which you have active clinical privileges in good standing
 facility name _____
 address _____
 city, state, zip _____
 status of Clinical Privileges _____
- F. MEDICAID/MEDICARE -Disclosure of whether you participate in medicaid and medicare programs (but not necessarily accepting new patients), or have ever been barred from participation in either program
 Do you participate in medicaid? Yes No Ever been barred from participation? Yes No
 Do you participate in medicare? Yes No Ever been barred from participation? Yes No
- G. TRANSLATING SERVICES - Disclosure of any translating services that may be available at your practice locations (optional)
 What language and where? _____
- H. CRIMINAL HISTORY - Description of any criminal convictions for felonies or other crimes of moral turpitude against you within the most recent 10 years. For purposes of this subsection, you shall be deemed convicted of a crime if you pled guilty or were found or adjudged guilty by a court of competent jurisdiction
 List conviction description, charge & date _____
- I. BOARD DISCIPLINARY HISTORY - Description of any final disciplinary actions, including but not limited to revocation or suspension of license, taken against you by any board from any state within the most recent 10 years
 List disciplinary action, state, charge, & date _____
- J. OTHER DISCIPLINARY HISTORY - Description of any revocation or involuntary restriction of your hospital privileges, or a reduction in your credentialing for more than 180 days, from any state, for reasons related to your competence or character, that have been taken by a hospital's governing body or any other official of a hospital against you after procedural due process has been afforded; or your resignation from or non-renewal of a medical staff membership, or the restriction of your privileges at a hospital taken in lieu of or in settlement of a pending disciplinary case related to your competence or character in that hospital, within the most recent 10 years
 List privilege sanction, hospital, reason, & date _____
- K. PROFESSIONAL LIABILITY INSURANCE - Disclose whether or not you carry professional liability insurance, and if you have ever been denied professional liability insurance
 Do you carry professional liability insurance? Yes No
 Have you ever been denied professional liability insurance? Yes No
- L. MALPRACTICE HISTORY - Disclose all malpractice court judgments and all malpractice arbitration awards against you in which a payment was awarded to a complaining party during the most recent 10 years. Disclosure of pending malpractice claims is not required.
 List judgment, award, & date _____
- M. SETTLEMENT HISTORY - Disclose all settlements of professional malpractice claims against you within the most recent 5 years of continuous practice;
 (i) You need only disclose malpractice settlements if there have been 5 or more settlements in the most recent 5 years of continuous practice, of \$50,000, or more, per settlement, or if there have been more than 10 settlements within the most recent 5 years of continuous practice of any dollar amount;
 (ii) Settlements that result solely in an adjustment to the fee charged for your services shall not be disclosed pursuant to this chapter;
 (iii) Information concerning all settlements shall be accompanied by the following statement: "Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of a provider. A payment in settlement of a malpractice action or claim should not be construed as creating presumption that malpractice has occurred. Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation.";
 (iv) Nothing herein shall be construed to limit or prevent the board from providing further explanatory information regarding settlements;
 List settlement amount & date _____

N. PROFESSIONAL OWNERSHIP - Disclose the percentage of ownership interest you have in other health facilities, laboratories, equipment or therapy, except for ownership interest in the primary practice business, to which your patients are, have been, or may be referred.
Facility name & percentage _____

I hereby swear (or affirm) under oath that the information provided above is true and correct to the best of my knowledge. I understand that neither the Board that issues my license/registration nor the entity providing the profile shall be held liable for the correctness or completeness of the information contained in my profile. I further understand that any release of the information provided by me will include a disclaimer statement attesting to the self-reporting nature of the program, and that the information has not been verified by the board or the reporting entity. I further understand that my failure to provide a full and truthful disclosure of information to the board within the time specified, may result in a fine of up to fifty dollars (\$50.00) for each day that I am not in compliance with the requirement to report and that the board may take any other disciplinary action it deems appropriate, except the board may not revoke, suspend, refuse to issue or refuse to renew a license or registration solely because I failed to comply with the requirement to report.

applicant/licensee/registrant signature

State of _____, County of _____, ss.
Subscribed and sworn before me this _____ day of _____, 20 _____.

(seal)

Notary Public official signature
my commission expires _____

PLEASE ENTER YOUR PROFILE INFORMATION ONLINE AT:
<http://www.idacare.org/update/userentry.cfm>

If you do not have Internet access, you may mail your profile information to:

IDACARE
PO Box 190720
Boise, ID 83709

