



## PRACTICE SITUATION

<b>Type</b>	Solo Practitioner (# of years)	Partnership/Group (# of partners)
	Professional Corporation (name)	Other (briefly explain)
<b>Situation</b>	Is your practice limited to a specialty or subspecialty?	Yes                      No
	If yes, list specialty/subspecialty	Average # of patients seen per day
<b>Clinical Practice</b>	Percentage of time spent in clinical practice	Number of hours/week spent in clinical practice

## BOARD CERTIFICATION

List all specialty and/or subspecialty boards	Initial certification date	Most recent certification date

## LICENSURE

Name of state where you are licensed or have ever been licensed	Indicate the status of that license (either ACTIVE or INACTIVE)

### DISCIPLINARY ACTIONS

Please indicate all incidents of disciplinary action(s).  
 Attach an explanation of each action in a separate document.

State	Type of Action	Date of Action

Professional Society	Type of Action	Date of Action

Hospital Privileges	Type of Action	Date of Action

### MALPRACTICE

List all malpractice settlements, judgments, or pending cases.  
 Attach an explanation of each action in a separate document.

Amount of Settlement/Judgment	Date of Settlement (or specify "pending")

### COMMITTEE EXPERIENCE

Name of Committee	Name of Hospital/Institution	Dates Served

## REVIEWER EXPERIENCE

### For Agency

Name of Review Agency	Dates served as reviewer

### For Medical Malpractice

On behalf of the plaintiff or defendant?	Testimony or deposition required?

*To be considered as a medical expert complaint reviewer, please email this completed form along with a current curriculum vitae to [med.compliance@med.ohio.gov](mailto:med.compliance@med.ohio.gov).*