



### 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

<b>Board Certification</b>	List all specialty and/or subspecialty boards	Dates of initial certification & last re-certification
	1.	Initial ----- Last
	2.	Initial ----- Last
	3.	Initial ----- Last
	Please state the specialty(s) or subspecialty(s) you would be interested in reviewing	

### LICENSURE

<b>Out-of-State Licensure</b>	Please list all states where you are licensed or have ever been licensed	Please indicate the status of that license (either ACTIVE or INACTIVE)
1.		
2.		
3.		
4.		
5.		

### DISCIPLINARY ACTIONS

Please indicate all incidents of disciplinary action(s). Attach an explanation of each action on a separate piece of paper.

State	Type of Action	Date of Action
1.		
2.		
3.		
Professional Society	Type of Action	Date of Action
1.		
2.		
3.		
Hospital Privileges	Type of Action	Date of Action
1.		
2.		
3.		

### MALPRACTICE

List all malpractice settlements, judgments, or pending cases. Attach additional information on a separate piece of paper.

Malpractice	Amount of Settlement/Judgment	Date of Settlement (or specify "pending")
1.		
2.		
3.		
4.		
5.		

### COMMITTEE EXPERIENCE

<b>Hospital Committee Experience</b>	Name of Committee	Name of Hospital	Dates Served
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

### REVIEWER EXPERIENCE

<b>For Agency</b>	Name of Review Agency	Dates served as reviewer
1.		
2.		
3.		
4.		
<b>For Medical Malpractice</b>	On behalf of the plaintiff or defendant?	Testimony or deposition required?
1.		
2.		
3.		
4.		