National Emergency Tele-Critical Care Network
Provider Volunteer Survey and Attestation

Last Name: First Name:

Best Contact Phone Number: Email Address:

Provider Type: [Select or Enter New Type] DEA Registration (Federal or State Programs)?

Other Professional Registration/License? Licensed? Clinical Privileges?

Membership/Rights on any medical staff? Site:

Professional society membership or Fellowship? Hospital Affiliation/Status?

Board Certified or Eligible?

Compensation Status:

(●) I wish to VOLUNTEER my services without compensation.

( ) I want to be compensated for my services.

National Provider Identifier(NPI):

Please answer the following questions with Yes or No using the drop-down box:

1) Has your license to practice in any state ever been subject to review, investigation, relinquished, denied, limited, suspended, or revoked (either voluntary or involuntary)?

2) Have any disciplinary actions or investigations been initiated or are any pending against you by any state licensure board?

3) Have our privileges at any hospital been suspended, diminished, revoked, or not renewed for any reason?

4) Have you ever been asked to surrender your license?

5) Has your narcotics registration certificate (DEA) ever been subject to review, investigation, relinquished, denied, limited, suspended or revoked (either voluntary or involuntary)?

6) Is your narcotics registration certificate (DEA) currently subject to review or investigation?

7) Has your membership, or renewal thereof, in any professional association ever been denied, suspended, revoked, surrendered or been subject to disciplinary proceedings?

8) Have you ever been denied employment, medical staff appointment and/or clinical privileges, or the renewal thereof, at any hospital or health care facility, or ever been subjected to disciplinary proceedings such as having your privileges suspended, diminished, limited, refused, or revoked (either voluntary or involuntary) at any hospital or health care facility?

9) Have you ever withdrawn your application for appointment, reappointment, and/or clinical privileges, or resigned from a medical staff before a decision was made by any hospital's or health care facility's governing board?

10) Have you ever been convicted of a felony?

11) Have you ever had a board certification revoked?

12) Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal, or state health insurance program (for example, Medicare, Medicaid)?

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13) Have you ever been the subject of any investigation or review by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program?

14) Has your professional liability insurance coverage ever been terminated by action of the insurance company?

15) Have you ever been denied professional liability insurance coverage?

16) Has your present professional liability insurance carrier excluded any specific procedures from your coverage?

17) Have any professional liability claims or suits ever been filed against you?

18) Are there any professional liability claims or suits presently pending against you?

19) Have any judgments been entered against, or settlements been made with you in professional liability cases?

20) During the past two years, have you been involved in any claim or suit for alleged malpractice?

21) Do you now have, or have you had within the past three years, a physical or mental condition, specifically including, but not limited to, alcohol or drug dependency which could affect your ability to exercise the clinical privileges requested?

22) If you answered "Yes" to the question 21 above, would you require an accommodation in order for you to exercise the privileges requested safely and competently?

Please annotate your availability as a volunteer by checking the boxes below: Timezone:

Shift	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Day (7:00am - 3:00pm)	☐	☐	☐	☐	☐	☐	☐
Evening (3:00pm - 11:00pm)	☐	☐	☐	☐	☐	☐	☐
Night (11:00pm - 07:00am)	☐	☐	☐	☐	☐	☐	☐
Anytime	☐	☐	☐	☐	☐	☐	☐

Other Times:

Notice of Data Collection: The information on this Provider Volunteer Survey is being collected for screening of your provider status prior to referral to one of the NETCCN Clinical Teams. The NETCCN Clinical Team will further use this information for emergency credentialing activities with each healthcare delivery organization that you will be supporting. The NETCCN Operations Cell will retain this information in an Electronic Data Management System rated for securely storing Personally Identifiable Information to facilitate reassignment between NETCCN clinical teams and for future emergency response opportunities. This information will not be used for reassignment between NETCCN clinical teams, assignment to future emergency response opportunities, or any other purpose without your prior consent.

Signature Date

Please send completed and signed form to email: usarmy.detrick.medcom-usamrmc.mesg.netccn-operations-officer@mail.mil