

**MARYLAND INSURANCE ADMINISTRATION  
MEDICAL DIRECTOR  
APPLICATION FOR RE-CERTIFICATION**

Answer each question and return the completed application form to:

**Medical Director/Private Review Agent Oversight Unit  
Maryland Insurance Administration  
200 St. Paul Place, Suite 2700  
Baltimore, Maryland 21202-2272  
(410) 468-2215**

This application must be accompanied by a check or money order in the amount of \$100.00 payable to the *Maryland Insurance Administration*.

**1. Name of Applicant:**

First \_\_\_\_\_

Middle \_\_\_\_\_

Last \_\_\_\_\_

Suffix(*e.g., Sr., Jr., II, etc.*) \_\_\_\_\_

**2. a. Previous Name of Applicant:** *Has the applicant ever used a name that is different from the above?*

YES

NO

**b.** *If yes, enter any previous name(s). Legal documentation of a name change must accompany this application. Acceptable proof of a name change includes: a photocopy of a divorce decree, a photocopy of a marriage certificate, or photocopy of a court document.*

\_\_\_\_\_  
\_\_\_\_\_

**3. Applicant Contact Information:**

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Personal (Cell/Home) Phone Number: \_( \_\_\_\_\_ ) \_\_\_\_\_

Business Phone Number: \_( \_\_\_\_\_ ) \_\_\_\_\_

Email Address: \_\_\_\_\_

4. **Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

5. **Date of birth:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

6. **Gender:** Male  Female

7. **Applicant Employer Information:**

Applicant Job Title: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

\_\_\_\_\_

Employer Phone Number: \_( \_\_\_\_\_ ) \_\_\_\_\_

Employer Facsimile: \_( \_\_\_\_\_ ) \_\_\_\_\_

Date of Hire as Medical Director:

a. Actual: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

b. Expected, (if applicable): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

8. **Administrative Contact Person:** Identify a contact person who will be available to respond to inquiries from the Maryland Insurance Administration regarding this application. This will also be the person to whom all future correspondence and certification documents will be mailed.

Name and Job Title: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_( \_\_\_\_\_ ) \_\_\_\_\_

Facsimile: \_( \_\_\_\_\_ ) \_\_\_\_\_

Email Address: \_\_\_\_\_

9. **Hours of Contact:** At what time during the normal business day is the contact person available by telephone? Use Eastern Standard Time as your reference.

\_\_\_\_\_

10. **Certification by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA):**

Name of Specialty Board	Subspecialty	Year Certified	Year Re-Certified	Expiration Date

11. **Education (*Advanced Health Related Degree--Other Than MD/DO*):** List only those obtained since previous certification.

a. Name of Institution:

\_\_\_\_\_

Current mailing address (*street name, city, state, and any postal codes*):

\_\_\_\_\_

Dates attended: From: (month/year)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ To: (month/year)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Degree Conferred: \_\_\_\_\_

b. Name of Institution:

\_\_\_\_\_

Current mailing address (*street name, city, state, and any postal codes*):

\_\_\_\_\_

Dates attended: From: (month/year)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ To: (month/year)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Degree Conferred: \_\_\_\_\_

**12. Internship/Training:** List only any training obtained since previous certification.

- a.  PGY I (internship)  PGY II and III(residency)  PGY IV & Greater(fellowship)  Other \_\_\_\_\_

Institution (*use the name the institution is currently known by*):

\_\_\_\_\_

Current mailing address (*street name, city, state, and any postal codes*):

\_\_\_\_\_

\_\_\_\_\_

Dates attended: From: (month/year)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ To: (month/year)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Specialty:\_\_\_\_\_  Clinical  Research

- b.  PGY I (internship)  PGY II and III(residency)  PGY IV & Greater(fellowship)  Other \_\_\_\_\_

Institution (*use the name the institution is currently known by*):

\_\_\_\_\_

Current mailing address (*street name, city, state, and any postal codes*):

\_\_\_\_\_

\_\_\_\_\_

Dates attended: From: (month/year)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ To: (month/year)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Specialty:\_\_\_\_\_  Clinical  Research

**13. Work Experience/Employment:** List only new employment gained since previous certification.

- a. Institution (*use the name the institution is currently known by*):

\_\_\_\_\_

Current mailing address (*street name, city, state, and any postal codes*):

\_\_\_\_\_

\_\_\_\_\_

Dates of service: From: (month/year)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ To: (month/year)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Staff Category (*active, courtesy, administrative, etc.*): \_\_\_\_\_

Name of Department Chair/Supervisor: \_\_\_\_\_

Type of Facility (*acute, inpatient care, outpatient, faculty/academic appointment, private office, etc.*):

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**b.** Institution (*use the name the institution is currently known by*):

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Current mailing address (*street name, city, state, and any postal codes*):

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Dates of service: From: (month/year)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ To: (month/year)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Staff Category (*active, courtesy, administrative, etc.*): \_\_\_\_\_

Name of Department Chair/Supervisor: \_\_\_\_\_

Type of Facility (*acute, inpatient care, outpatient, faculty/academic appointment, private office, etc.*):

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**14. Screening Questions: Any affirmative response requires an explanation.** Place an “X” in the appropriate boxes. Submit complete details of any affirmative answer on a separate sheet of paper with this application.

Have any of the following ever been, or are currently in the process of being, either on a voluntary or involuntary basis: denied, revoked, suspended, reduced, limited, placed on probation, not renewed or relinquished for disciplinary reasons or in anticipation of disciplinary action?

**a.** Medical/Professional license in any state jurisdiction?

YES

NO

**b.** Membership on any hospital/medical staff?

YES

NO

**c.** Participation in any training program?

YES

NO

**d.** Clinical privileges?

YES

NO

e. Specialty board certification?

YES

NO

f. Participation in the Medicare/Medicaid program?

YES

NO

g. Federal DEA Registration?

YES

NO

h. State controlled substance registration?

YES

NO

15. Other than traffic violations, have you ever been convicted of, or pleaded guilty or *nolo contendere* to any crime?

YES

NO

16. Are you currently suffering from, or receiving treatment for, any physical or mental disability or illness, including drug or alcohol abuse, which may impair the proper performance of your duties and responsibilities as a medical director?

YES

NO

17. To the best of your knowledge, has any action ever been reported to the National Practitioner Data Bank (NPDB) in which you were named as a defendant?

YES

NO

18. **Insurance Information:** Since your most recent certification, have you been the subject of a professional liability suit, including, but not limited to malpractice claim(s) that may or may not have resulted in a lawsuit?

YES

NO

19. **An affirmative response for question 18 must be explained.** For each action taken, use the format provided below to explain your response. Provide the complete name and address for each carrier identified.

**Malpractice Claims History:**

Plaintiff(s):

\_\_\_\_\_

State In Which Suit Was Initiated: \_\_\_\_\_ Month & Year Suit Initiated: \_\_\_\_\_ / \_\_\_\_\_

Insurance

Carrier: \_\_\_\_\_

Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Nature of the claim:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Status of the Suit:** Filed  Awaiting Trial  Dismissed  Settled out of court

Other: \_\_\_\_\_

Expected trial date if suit is unresolved: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of outcome if suit was resolved: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**20. Licensure Information:** Complete all of the requested information. Provide a copy of each license.

Licensures	Number	Expiration Date
<b>Maryland</b> Medical License		
Other State License (Name of State) _____		
Other State License (Name of State) _____		
Other State License (Name of State) _____		
Other State License (Name of State) _____		
Other State License (Name of State) _____		

Other State License (Name of State) _____		
Other State License (Name of State) _____		
Other State License (Name of State) _____		
Other State License (Name of State) _____		
Other State License (Name of State) _____		

**21. Health Maintenance Organization Contact Information:** List each health maintenance organization (HMO) licensed in Maryland for whom you have medical director responsibilities. The name, address, and telephone number of each HMO with whom you are employed or under contract must be provided. Also provide the name of the governing authority of each HMO. Governing authority is defined as the person or persons designated in the by-laws with the responsibility of operating the HMO. Attach additional sheets if necessary.

**a.** HMO Name: \_\_\_\_\_  
HMO Governing Authority: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State, Zipcode: \_\_\_\_\_  
Telephone Number: \_\_ (\_\_\_\_) \_\_\_\_\_

**b.** HMO Name: \_\_\_\_\_  
HMO Governing Authority: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State, Zipcode: \_\_\_\_\_  
Telephone Number: \_\_ (\_\_\_\_) \_\_\_\_\_

**22. Financial Information:** Disclose ALL methods of compensation received from the employer listed in question 7 and (if different) each HMO listed in question 21, including any related holding company (ies). Compensation includes, but is not limited to salary, stock options, bonuses, fees for attending Board of Directors or Appeal Panel meetings, profit sharing, etc.

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**23. Medical Director Status:** Place an “X” where appropriate. **Briefly describe your duties as medical director.**

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Chief Medical Director	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Assistant or Associate Medical Director	YES <input type="checkbox"/>	NO <input type="checkbox"/>

**CRITERIA CERTIFICATION**

I hereby certify that the criteria and standards used in conducting utilization review for

are:

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(Insert Name of Each HMO Identified in Question 21)

- (I) Objective.
- (II) Clinically Valid.
- (III) Compatible with established principles of health care, and
- (IV) Flexible enough to allow deviations from norms when justified on a case by case basis.

Medical Director (Type in Name)

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Signature

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*WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION MAY BE PROSECUTED UNDER APPLICABLE STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OR REVOCATION OF CERTIFICATION.*

**AUTHORIZATION**

I hereby certify that this application has been examined by me and is true, correct, and complete to the best of my knowledge and belief. I understand that the information required herein is continuing in nature, and I agree to supplement the information provided as changes occur. I understand that any misstatements or inaccuracies in, or omissions from, this application may constitute a denial or revocation of Certification, and that such denial or revocation may result in a report to the Board of Physician Quality Assurance or other applicable licensing or regulatory entity.

I authorize the Maryland Insurance Administration and its contractor to consult with schools, licensing boards, hospitals, professional organizations, insurers and individuals to compile my complete professional history and qualifications to be a medical director, including evidence of my good character and trustworthiness. I acknowledge that this includes, but is not limited to, the Board of Physician Quality Assurance, current and past employers, medical boards, educational institutions, and professional groups with which I have been affiliated. Furthermore, I consent to the release of information, including otherwise privileged or confidential information, to the Maryland Insurance Administration and its contractors from all of the entities and individuals described herein for the purposes of compiling my complete professional history and qualifications to be a medical director, including evidence of my good character and trustworthiness.

Name of Applicant: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_