

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

**Review the Instructions *before* completing this re-certification application.** Answer each question and return the completed application form and all attachments to [medicaldirectorsubmissions.mia@maryland.gov](mailto:medicaldirectorsubmissions.mia@maryland.gov). A fee in the amount of \$100 is due at the time of application. Send a check or money order payable to the *Maryland Insurance Administration to:*

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

Please include a letter with information telling us what the check is form (i.e. Medical Director Re-certification) and who the doctor is. Also send a copy of the check either with this re-certification application submission or separately to [medicaldirectorsubmissions.mia@maryland.gov](mailto:medicaldirectorsubmissions.mia@maryland.gov).

The filing will not be processed until the fee is received.

**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 re-certification 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. Note we only need this documentation once. We do not need it with every re-certification application.*

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**3. Applicant Contact Information:**

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

\_\_\_\_\_

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

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

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

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

**6. Gender:** Male  Female

**7. Applicant Employer Information:**

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

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

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

\_\_\_\_\_

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

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 re-certification application. This will also be the person to whom all future correspondence and certification documents will be mailed. Typically, the Administrative Contact Person is the HMO.

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

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

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



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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*):

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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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**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 pagewith this re-certification 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)		

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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 the legal HMO entity’s name for 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, Zip : \_\_\_\_\_



**CRITERIA CERTIFICATION**

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

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are:

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(Insert Legal HMO Entity 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 re-certification 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 re-certification 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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_