



P.O. Box 3458
Valdosta, GA 31604
(229) 247-5153

**PRE-APPLICATION QUESTIONNAIRE
FOR PODIATRISTS (DPM'S)**

[Redacted]

Date: _____

Name As It Appears on Medical License: _____

Name of Practice: _____

Specialty: _____

Office Physical Address: _____

Office Mailing Address: _____

Office Telephone Number: _____

Office Fax Number: _____

Office Manager/Credentialing Contact: _____

Residence Address: _____

Residence Telephone Number: _____

	<i>Yes</i>	<i>No</i>
Do you have a current, unrestricted license to practice in Georgia?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a license to practice revoked or suspended by any state licensing agency?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a current and unrestricted Drug Enforcement Administration registration?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have current professional liability insurance coverage with minimum limits of \$1,000,000/\$3,000,000?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payor fraud or program abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been required to pay civil penalties any fraud or abuse listed above?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been excluded or precluded from participation in Medicare, Medicaid or other federal or state governmental health programs?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had medical staff appointment or clinical privileges denied, revoked, resigned, relinquished or terminated by any healthcare facility or health plan for reasons related to clinical competence or professional conduct?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Have you ever been convicted of, or entered a plea of guilty or no contest to any crime against children, any misdemeanor relating to controlled substances, illegal drugs, insurance or healthcare fraud or abuse or violence, or any felony?	<input type="checkbox"/>	<input type="checkbox"/>
Have you completed a residency and/or fellowship? Year of Completion _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently have clinical hospital privileges at a hospital accredited by the Joint Commission on the Accreditation of Health Care Organizations?	<input type="checkbox"/>	<input type="checkbox"/>
Did you graduate from a college of osteopathic medicine accredited by the American Osteopathic Association?	<input type="checkbox"/>	<input type="checkbox"/>
Are you Board Certified by the American Board of Podiatric Surgery or do you meet the training and experience or any time limit requirements for certification by such Board including having completed a two-year residency program approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association?	<input type="checkbox"/>	<input type="checkbox"/>



This completed Questionnaire must be returned with copies of the following documents:

- (a) Current license(s) to practice your profession;
- (b) Current DEA registration
- (c) Certificate of coverage from professional liability insurance carrier;
- (d) ECFMG certificate (if foreign medical graduate); and
- (e) A current curriculum vitae

Those individuals who are not Board Certified at the time of application for membership but who have completed their residency training within the last five (5) years shall be eligible to participate in SGPN. However, in order to remain eligible, those individuals must achieve Board Certification or meet the training and experience and any time limit requirements for such certification within five (5) years from the date of completion of their residency training.



I request an application to become a Participating Provider. I certify that I meet the prerequisites for receiving an application to become a Participating Provider. I understand that the information requested on this Pre-Application Questionnaire is necessary for South Georgia Physician Network to make an administrative determination as to whether I am eligible to receive an application. The Pre-Application Questionnaire does not constitute an application. I understand that a determination that I am ineligible to receive an application does not give rise to any procedural rights.

I hereby release from any and all liability, and agree not to sue, South Georgia Physician Network, LLC, and its representatives for their actions in connection with evaluating the information provided on this Questionnaire and determining whether or not I am eligible to receive an application.

Date

Signature