

Center for a Healthy Maryland
Maryland Physician Health Program
PRACTITIONER INFORMATION FORM

NAME: _____

DATE OF BIRTH: _____ **GENDER:** _____

ETHNIC BACKGROUND: _____ **MARTIAL STATUS:** _____

PRACTITIONER TYPE: MD DO PA RESIDENT STUDENT Other: _____

PHYSICIAN SPECIALTY: _____

Home Phone: _____ Can we leave a message? Yes No

Work: _____ Can we leave a message? Yes No

Cell: _____ Can we leave a message? Yes No

Email: _____ Private e-mail account? Yes No

PREFERRED METHOD OF CONTACT: _____

PREFERRED ADDRESS: _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____

PHONE: _____ **ADDRESS:** _____

ARE YOU CURRENTLY PRACTICING? YES NO

PRACTICE SETTING: N/A Solo Private Group Hospital HMO
Private Clinic Public Clinic Retired Other: _____

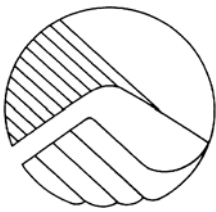
PLEASE LIST STATES IN WHICH YOU CURRENTLY HOLD A LICENSE:

1. _____ 2. _____

3. _____ 4. _____

HAVE YOU HELD A LICENSE IN ANY OTHER STATE: YES NO

IF YES, PLEASE LIST:



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PLEASE LIST ALL HOSPITAL AND HEALTH ORGANIZATION PRIVILEGES:

1. _____
2. _____
3. _____
4. _____

REASON FOR YOUR VISIT:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Self Prescribing |
| <input type="checkbox"/> Sexual Misconduct | <input type="checkbox"/> Sexual Harassment | <input type="checkbox"/> Personality Problem | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Anger Outbursts | <input type="checkbox"/> DWI | <input type="checkbox"/> Disruptive Behavior | |

Other Specify: _____

PLEASE COMMENT ON REASON(S) FOR VISIT:

MEDICAL CONDITIONS:

PRIMARY CARE PHYSICIAN: _____ **LAST PHYSICAL:** _____

LIST OF ANY MEDICATIONS:

_____	_____
_____	_____
_____	_____
_____	_____