

Maryland Professional Rehabilitation Program

1202 Maryland Ave,
Baltimore, MD 21201-5512
Phone: 410.878.9843
Fax: 410.878.9538

PARTICIPANT INFORMATION

DATE: _____ NAME: _____

DATE OF BIRTH: _____ GENDER: _____

LICENSE NUMBER: _____ MARITAL STATUS: _____

PRACTITIONER TYPE: MD DO PA Other: _____ ETHNIC BACKGROUND: _____

PHYSICIAN SPECIALTY (LIST ALL:) _____

NON-PHYSICIAN FIELD/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/EMAIL: _____

IF YOU ARE CURRENTLY PRACTICING, PLEASE CIRCLE PRACTICE SETTING(S):

N/A Retired Solo Private Group Hospital HMO Private Clinic Public Clinic

Other: _____

PLEASE LIST ALL STATES IN WHICH YOU CURRENTLY HOLD A LICENSE/CERTIFICATE:

1. _____ 2. _____

3. _____ 4. _____

HAVE YOU HELD A LICENSE IN ANY OTHER STATE IN THE PAST: NO YES (specify):

LIST ALL HOSPITALS AND HEALTH ORGANIZATIONS WHERE PRIVILEGED, OR PLACE OF PRACTICE/EMPLOYMENT:

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

LIST RENEWAL DATES FOR YOUR STATE LICENSE(S); OR, IF YOU ARE APPLYING FOR A NEW LICENSE IN THIS STATE OR OTHER STATES, PLEASE LIST YOUR APPLICATION DATE(S): NOT APPLICABLE

- | | |
|----------------------|----------------------|
| 1. _____ DATE: _____ | 2. _____ DATE: _____ |
| 3. _____ DATE: _____ | 4. _____ DATE: _____ |

LIST RENEWAL DATES FOR ANY CERTIFICATION(S); OR, IF YOU ARE APPLYING FOR A NEW CERTIFICATE, PLEASE LIST CERTIFICATION AND APPLICATION DATE(S): NOT APPLICABLE

- | | |
|----------------------|----------------------|
| 1. _____ DATE: _____ | 2. _____ DATE: _____ |
|----------------------|----------------------|

PLEASE CHECK HOW YOU WERE REFERRED TO THIS PROGRAM:

- BOARD ORDER** (Formal, public, written decision of the Board)
- CONSENT AGREEMENT** (Formal written nonpublic agreement entered into between the Board and a physician or allied health professional wherein the licensed practitioner agrees to comply with certain conditions and the Board will forego further investigation into a matter based on compliance with those conditions.)

PLEASE COMMENT ON YOUR UNDERSTANDING OF THE REASON(S) FOR THIS APPOINTMENT:

PRIMARY CARE PHYSICIAN: _____ DATE OF LAST PHYSICAL: _____

LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING:
