Maryland HealthCare Professionals Program

1202 Maryland Ave,
Baltimore, MD 21201-5512
Phone: 410.962.5580
Fax: 410.962.5583

PARTICIPANT INFORMATION

DATE: _____ NAME: _____

DATE OF BIRTH: _____ GENDER: _____

LICENSE NUMBER: _____ MARITAL STATUS: _____

PRACTITIONER TYPE: _____ ETHNIC BACKGROUND: _____

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._____

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.)

☐***DISPOSITION AGREEMENT*** (Private non-public agreement)

☐***SELF-REFERRAL*** (Voluntary)

REASON FOR YOUR VISIT:

___Alcohol Abuse ___Drug Abuse ___Psychiatric Illness ___Self Prescribing
___Sexual Misconduct ___Sexual Harassment ___Personality Problem ___Legal
___Anger Outbursts ___DWI ___Disruptive Behavior
___Other Specify:
_____

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:

_____

_____

_____