Mid-Valley Behavioral Care Network Staff Adverse Actions Report
Staff Disclosure Form

The following information from individual clinical staff are required as part of the MVBCN *credentialing process. These questions are designed to apply to staff at all levels of professional training and licensure. Answer "NO" to questions which do not apply to your discipline.* ***INFORMATION SUBMITTED TO MVBCN DURING PREVIOUS RECREDENTIALING REVIEWS SHOULD NOT BE INCLUDED ON THIS FORM.***

1. LIABILITY EXPERIENCE:

If the answer to the following questions is a "yes", please provide specifics: ***date claim initiated, nature of claim, names of parties, name and location of court, description of status or disposition.***

1.1 Have there ever been or are there currently pending any malpractice claims, settlements, judgments or arbitration proceedings involving professional practice? **[ ] Yes [ ] No**

1.2 Has professional liability coverage ever been terminated by the carrier? **[ ] Yes [ ] No**

1.3 Has professional liability coverage ever been denied? **[ ] Yes [ ] No**

1.4 Has the carrier ever excluded any specific procedure or practice from the coverage? **[ ] Yes [ ] No**

2. ADVERSE ACTIONS:

Have any of the following ever been or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily or involuntarily relinquished, or have you ever withdrawn or failed to proceed with an application for any of the following? *If yes, please provide full explanation on a separate sheet.*

2.1 Professional registration/ license in any state? **[ ] Yes [ ] No**

2.2 DEA/controlled substance registration? **[ ] Yes [ ] No**

2.3 Any other type of professional sanction? **[ ] Yes [ ] No**

2.4 Membership, clinical privileges or prerogatives/rights on any hospital medical staff? **[ ] Yes [ ] No**

2.5 Professional society membership or fellowship certification? **[ ] Yes [ ] No**

2.6 Medicaid or Medicare provider status? **[ ] Yes [ ] No**

3. OTHER ACTION TAKEN:

To your knowledge have you ever been the subject of an individual focused review required by PSRO, PRO or similar peer review agency? *If yes, please provide full explanation on separate sheet.* **[ ] Yes** **[ ] No**

I understand that my application for membership in the Mid-Valley Behavioral Care Network may require a thorough review of information regarding my past or present status with any licensing Boards or professional organizations and malpractice insurers. I hereby authorize release of all such information and understand that all such information will be reviewed in strict confidence to the degree permitted by law. No information obtained or reviewed will be re-released without my additional consent in writing. This information will be subject to the same privacy protections given employees of their respective employer.

I understand that any information received about me/my application will be available for my review and comment at any time I may so request. This release will remain in effect throughout the duration of my membership with the MVBCN, or until canceled by me in writing.

All information submitted in this application is true to my best knowledge and belief. I fully understand that any significant misstatement in or omission from this application as well as any change in, or failure to inform the MVBCN of any changes in, information provided on this application, may constitute cause for denial of participation or cause for dismissal from the MVBCN.

SIGNATURE

Name (print or type) ____

Signature ________________________________ Date ________________

Job Position ____

Agency or Program ____