

# General Attestation Form

Please answer yes or no to each of the following questions. If there is a yes response, please describe the circumstances on a separate sheet of paper. Indicate N/A for any question that does not apply. Please note that answering yes to any question does not necessarily disqualify you from participation in the ACBN. The information is sought as part of the overall credentialing process.

Yes \_\_\_ No\_\_\_ Prior malpractice or civil judgments or settlements?

Yes \_\_\_ No\_\_\_ Pending personal or professional claims?

Yes \_\_\_ No\_\_\_ Has your professional liability insurance ever been cancelled or renewal refused?

Yes \_\_\_ No\_\_\_ Have you ever been denied a request for hospital privileges, or have your privileges ever been voluntarily or involuntarily revoked, suspended or terminated?

Yes \_\_\_ No\_\_\_ Has your license to practice in any state or country ever been revoked, suspended, or otherwise, limited (whether or not such revocation, suspension or limitation was stayed)?

Yes \_\_\_ No\_\_\_ Has any disciplinary action(s), investigation(s), ever been initiated or are any pending against you by a state or federal agency?

Yes \_\_\_No\_\_\_ Have you ever been censured, reprimanded, excluded, suspended, or disqualified by the Medicare or Medicare programs?

Yes \_\_\_No\_\_\_ Have you ever been convicted of, or pleaded no contest to, any criminal charges brought against you?

Yes \_\_\_No\_\_\_ Do you currently use drugs or alcohol to the point that it might affect your ability to practice or place your patients at increased risk?

Yes \_\_\_No\_\_\_ Have you ever been refused or suspended from a state or federal program?

Yes \_\_\_ No\_\_\_ Have you had any licensing authority or regulatory agency actions e.g. probation, administrative warning, suspension, fines, etc.?

Yes \_\_\_No\_\_\_ Do you or any member of your family have ownership or other financial interest in any business which provides ancillary health services, equipment, pharmaceuticals, laboratory services, or supplies to which you do, or will refer health care business?

Yes \_\_\_No\_\_\_ During the past five (5) years, from date of occurrence, filing or resolution, with or without monetary settlement, have you had any malpractice suits or proceedings related to your practice? Please describe each case.

Yes \_\_\_No\_\_\_ During the past five (5) years has your malpractice insurance ever been cancelled, not renewed or has your malpractice risk pool been cancelled?

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Signature

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Date