MAXIMUS Federal

Consultant Application

Fax: (585)869-3390 Email: ProfessionalRelations@maximus.com
3750 Monroe Avenue, Suite 700, Pittsford, New York 14534

Personal Information

Name

Sex

Male: ◯ Female: ◯

Home Address

Social Security Number

Date of Birth

Contact Information

Home Phone:

Email:

Home Fax:

Other (Cell, Pager, etc.):

New York Resident

Yes: ◯ No: ◯ If No, list State:

U.S. Citizenship

Yes: ◯ No: ◯

Military Service

Yes: ◯ No: ◯

Place of Birth

City:

State/Province:

Country:

Languages (other than English)

1. Speak: Read: Write:
2. Speak: Read: Write:
3. Speak: Read: Write:
4. Speak: Read: Write:

Drug Enforcement Agency Certificate No.

NPI (National Provider Identifier) if applicable

Please attach a copy of the certificate

Education

Attach CV. (List formal and primary medical education only)

Undergraduate Education

College/University:

Address:

City/State/Zip:

Dates Attended: Graduation Date:

Degree(s):

Clinical Degree

College/University:

Address:

City/State/Zip:

Dates Attended: Graduation Date:

Degree(s):

Continuing Medical Education Credits

List all courses completed during the previous year

Professional Liability Insurance (if applicable)

Insurance Company

Policy Number

Address

Agent's Name

Max $ Per Occurrence

Max $ Per Aggregate

Provide the names and addresses of your liability carriers for the past 5 years, if different from your current carrier:

Have you ever been denied professional liability insurance?

Yes: ◯ No: ◯ If Yes, explain:

Has your professional liability insurance ever been terminated?

Yes: ◯ No: ◯ If Yes, explain:

Professional Licensing (Attach a copy of all certificates/professional licenses)

List the State(s) in which you hold or have held a professional license

State	License Number	Date Issued	Expiration Date

Specialty Certifications (Attach a copy of your certification(s))

	Certification	Certification Date	Expiration Date
1.			
2.			
3.			

Academic Appointments

Start with most recent.

1. Institution:
   Position: Dates:

2. Institution:
   Position: Dates:

3. Institution:
   Position: Dates:

4. Institution:
   Position: Dates:

Current Hospital Affiliations and Admitting Privileges

Please attach a copy of the declaration of privileges for each hospital or facility.

1. Facility: Location:
   Status: Dates:

2. Facility: Location:
   Status: Dates:

3. Facility: Location:
   Status: Dates:

4. Facility: Location:
   Status: Dates:

Current Employment (Include self, corporate, practice and other)

Company or Professional Corporation

Federal Tax ID#

Classify Employer

Hospital: ☐ Private Practice: ☐ Group Practice: ☐ University: ☐ Other: ☐

Address

Telephone

Fax

Days that you can be reached at this address

Sunday: ☐ Monday: ☐ Tuesday: ☐ Wednesday: ☐ Thursday: ☐ Friday: ☐ Saturday: ☐ None: ☐

Your title within your company or corporation

Contact Person

Classify your primary medical work

Current Medical Practice

Percentage (%) of time devoted to medical practice:

Subspecialty or focus of practice (optional):

Medical Areas that you feel comfortable reviewing

1.

2.

3.

Employment History (List most current first)

1. Employer

Position:

Dates:

Address:

Duties:

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2. Employer

Position:

Dates:

Address:

Duties:

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3. Employer

Position:

Dates:

Address:

Duties:

Employment History (List most current first)

4. Employer

Position:

Dates:

Address:

Duties:

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5. Employer

Position:

Dates:

Address:

Duties:

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6. Employer

Position:

Dates:

Address:

Duties:

Conflicts of Interest (List direct or familial relationships)

List each current or planned affiliation with any health insurer utilization review firm, provider network or drug/device supply company. MAXIMUS defines affiliation as an owner, shareholder, partner, officer, director, employee, consultant, contracted provider or a familial relationship to any of the above. Ownership of more than 5% or any commission, royalty or similar arrangement should be listed.

1. Entity Name

Affiliation

2. Entity Name

Affiliation

3. Entity Name

Affiliation

4. Entity Name

Affiliation

Questions

If the answer to any of the following is “Yes”, then please supply a detailed explanation on a separate sheet.

	Yes	No
A. Has your license to practice medicine or prescribe controlled substances in any jurisdiction ever been revoked, suspended, denied or voluntarily suspended, or is any such action or other disciplinary or misconduct action pending or withdrawn?	◯	◯
B. Have clinical privileges or staff membership at any hospital ever been denied, revoked, suspended, reduced, not renewed, voluntarily surrendered or withdrawn or is any such action pending or withdrawn.	◯	◯
C. Has membership in any medical organization ever been suspended, revoked, limited or denied, or is any such action pending or withdrawn?	◯	◯
D. Are there any pending administrative agency or court cases, or administrative agency or court decisions, judgment or settlements in which you are alleged to have violated, or was found guilty of violating any criminal law? (Exclude minor traffic violations)	◯	◯
E. Have any professional liability lawsuits ever been initiated against you?	◯	◯
F. Has any judgment or settlement been made against you in any professional liability case or is any case pending?	◯	◯
G. Are there any prior or pending government agency or third party payer proceedings or litigation challenging or sanctioning your patient admission, treatment, discharge, charging, collection or utilization practices, including but not limited to Medicare/Medicaid fraud and abuse proceedings and convictions?	◯	◯

If the answer to question D, E, F, or G is “Yes”, then , as part of the full detailed explanation required, please give the name of the court in which the lawsuit was brought, the caption and docket number of the case, the name and address of the attorney defending you, or the substance of the allegations in the lawsuit or proceeding.

Representations

I certify that the information on this application form is, to my knowledge, accurate, complete and true.

I understand that any misstatements in or omissions from this application constitute cause for non-eligibility or termination as a consultant.

I hereby release from liability any person or entity who provides information to MAXIMUS Federal concerning my application.

I hereby authorize MAXIMUS Federal and its representatives to consult with and solicit information from whatever third parties may have information bearing on the application and consent to the release and inspection of any such information.

This authorization shall be valid during the time my application is pending with MAXIMUS Federal, and shall be valid during each year thereafter while I maintain a consulting relationship with MAXIMUS Federal.

A photocopy of the authorization will be as valid as the original.

I certify that my mental and physical health status does not present any impediment to the treatment of patients and acting as a consultant to MAXIMUS Federal.

Should there be any changes in my licensure, hospital affiliation(s), insurance coverage, and/or address, I will immediately notify MAXIMUS Federal of the change.

Consultant Signature

Date

Print Name

Incomplete applications will not be considered