

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Yes ___ No___ Has your license to practice in any state or country ever been revoked, suspended, or otherwise, limited (whether or not such revocation, suspension or limitation was stayed)?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?

Signature

Date