



# TENNESSEE DEPARTMENT OF HEALTH

## MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE FOR LICENSED HEALTH CARE PROVIDERS

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. §§ 63-51-101, *et seq.*, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health, and is requested in this questionnaire. From the information submitted, the Department compiles practitioner profiles which the law requires to be made available to the public via the World Wide Web and our toll-free telephone line. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information may result in a delay or denial of your licensure application and/or may result in disciplinary action against your license. The professions required to submit a profile questionnaire are:

Advanced Practice Nurses  
Alcohol and Drug Counselors  
Audiologists  
Chiropractic Physicians  
Clinical Pastoral Therapists  
Dentists  
Dietitian/Nutritionists  
Dispensing Opticians  
Electrologists  
Licensed Registered Respiratory Therapists  
Licensed Certified Respiratory Therapists  
Licensed Laboratory Personnel  
Marital & Family Therapists  
Massage Therapists  
Medical Doctors

Nursing Home Administrators  
Occupational Therapists  
Optometrists  
Orthopedic Physician Assistants  
Osteopathic Physicians  
Pharmacists  
Physician Assistants  
Physical Therapists  
Podiatrists  
Professional Counselors  
Psychologists  
Respiratory Care Assistants  
Social Workers  
Speech Language Pathologists  
Veterinarians

A blank copy of the profile questionnaire may be obtained from the following web site address:  
<http://health.state.tn.us/Downloads/g6019027.pdf>.

# INSTRUCTIONS

**QUESTIONNAIRE DEADLINE** The provider must complete and submit the questionnaire before a license will be granted. Providers who have completed a similar questionnaire for another state's licensing board are, nevertheless, required to complete and submit this form.

**COMPLETING THE QUESTIONNAIRE** Complete the questionnaire by printing neatly in block letters in ball point pen or by typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.** If you need further instruction, contact your profession's licensing board by calling (615) 532-3202 or by calling toll free at (800) 778-4123.

**SUBMITTING THE QUESTIONNAIRE** Mail the completed profile questionnaire to:

Healthcare Provider Information Manager  
Tennessee Department of Health  
Division of Health Related Boards  
227 French Landing, Suite 300  
Heritage Place, MetroCenter  
Nashville, TN 37243

- ▶ **Do not return pages 1 through 4 with the questionnaire to the department**
- ▶ **Keep a copy of the questionnaire for your records.**

The following numbered parts correspond to the matching number on the questionnaire form.

## I. PRACTITIONER DATA

Complete Part I, noting the following:

- **License number:** Fill in your Tennessee license number and indicate your profession in the space provided. If you have not been issued a license number, please leave this blank.
- **Social security number:** **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- **Primary Practice Address:** Complete the practice address (if applicable). If your practice address is also your home address, you should know the Department is prohibited from placing your home address on the Internet without your request to do so. There is a box to check in Part I to request this. Retirees: Write in "N/A" for practice address. If you do not have a practice address at the time of completing this questionnaire, you must report your practice address within 30 days of obtaining a practice address.

## II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

### III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

### IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a “yes” answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

### V. STAFF PRIVILEGES

A. List all hospitals at which you hold staff privileges. The definition for “hospital” can be found at T.C.A. § 68-11-201.

B. In the spaces provided, answer information about the TennCare plans in which you participate and accept as a provider, if any. If there are more than five (5), please enclose an attachment.

### VII. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, frauds, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license such as censure, reprimand, probation, etc.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions B and C in Part VII in their entirety before answering those questions.

## **VIII. CRIMINAL OFFENSES**

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

## **IX. LIABILITY CLAIMS**

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19, 1998, you must indicate that claim in the space provided. **JUDGMENTS OR SETTLEMENTS BELOW THE FOLLOWING AMOUNTS ARE NOT REQUIRED TO BE SUBMITTED.**

- A) For Medical Doctors and Osteopathic Physicians, judgments or settlements below \$75,000 are not required to be submitted.
- B) For Chiropractors, judgments or settlements below \$50,000 are not required to be submitted.
- C) For Dentists, judgments or settlements below \$25,000 are not required to be submitted.
- D) For all other professions, judgments or settlements below \$10,000 are not required to be submitted.

Pending malpractice claims are not required to be reported unless/until final adjudication against you.

## **X. OPTIONAL INFORMATION**

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name \_\_\_\_\_ License # \_\_\_\_\_

Profession \_\_\_\_\_

**HEALTHCARE PROVIDER INFORMATION MANAGER  
TENNESSEE DEPARTMENT OF HEALTH  
DIVISION OF HEALTH RELATED BOARDS  
227 FRENCH LANDING, SUITE 300  
HERITAGE PLACE, METROCENTER  
NASHVILLE, TENNESSEE 37243**

**I. PRACTITIONER DATA**

A. PROFESSIONAL LICENSE NUMBER: \_\_\_\_\_ PROFESSION: \_\_\_\_\_

B. SOCIAL SECURITY NUMBER: \_\_\_\_\_ (This will not be published).

C. NAME (INCLUDE MAIDEN AND ON 2<sup>ND</sup>/3<sup>RD</sup> LINES ANY ALIASES, IF APPLICABLE):

CURRENT NAME:

\_\_\_\_\_  
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME)  
(IF APPLICABLE)

FORMER NAME(S):

\_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

\_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

D. PRIMARY PRACTICE ADDRESS:

\_\_\_\_\_  
(PRACTICE NAME)

\_\_\_\_\_  
(STREET NUMBER AND NAME)

\_\_\_\_\_  
(CITY) (STATE) (ZIP CODE)

Check here if your primary practice address is your home address and you want it to be published as part of the profile and on the web ..

E. E-MAIL ADDRESS: \_\_\_\_\_   
Your e-mail address will be published unless you elect not to by checking here.

F. WEB PAGE ADDRESS: \_\_\_\_\_   
Your web page address will be published unless you elect not to by checking here.

G. PRACTICE TELEPHONE: ( \_\_\_\_\_ ) \_\_\_\_\_   
Your telephone number will be published unless you elect not to by checking here.

H. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1. \_\_\_\_\_ 2. \_\_\_\_\_

I. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. \_\_\_\_\_

2. \_\_\_\_\_

Practitioner's Name \_\_\_\_\_ License # \_\_\_\_\_

Profession \_\_\_\_\_

**II. GRADUATE/ POSTGRADUATE MEDICAL EDUCATION AND TRAINING**

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE,COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			

**III. SPECIALTY BOARD CERTIFICATIONS:**

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) YES  NO   
 (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

Practitioner's Name \_\_\_\_\_ License # \_\_\_\_\_

Profession \_\_\_\_\_

**IV. FACULTY APPOINTMENTS**

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES  NO

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES  NO

If "YES", list the title of the appointment, name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

**V. STAFF PRIVILEGES**

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(9)) YES  NO

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

	NAME OF HOSPITAL	CITY/STATE
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

B. Do you currently participate in and accept any TennCare plan(s) as a provider? YES  NO

If "YES", list each plan in which you currently participate or accept as a provider: (Authority: T.C.A. § 63-51-105(a)(16))

	NAME OF TENNCARE PLAN
1.	_____
2.	_____
3.	_____
4.	_____
5.	_____

Practitioner's Name \_\_\_\_\_ License # \_\_\_\_\_

Profession \_\_\_\_\_

**VII. FINAL DISCIPLINARY ACTION (See Instructions):**

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8))  
YES  NO

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

AGENCY NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1. _____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

2. _____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
----------------------------	-------------------------	-------------------------	-------------------------

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted or reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-51-105(a)(4))  
YES  NO

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1. _____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

2. _____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
----------------------------	-------------------------	-------------------------	-------------------------

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

Practitioner's Name \_\_\_\_\_ License # \_\_\_\_\_

Profession \_\_\_\_\_

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by any hospital in lieu of or in settlement of a pending disciplinary action related to competence or character?(Authority: T.C.A.: § 63-51-105(a)(4))

YES  NO

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF ACTION
--	-----------------------	------	-----------------------

1.	_____	_____	_____
	_____		_____
	_____		_____

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

2.	_____	_____	_____
	_____		_____
	_____		_____

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

**VIII. CRIMINAL OFFENSES (See Instructions)**

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-51-105(a)(1)) YES  NO

If "YES" briefly describe the offense(s):

	DESCRIPTION OF OFFENSE(S)	DATE	JURISDICTION
--	---------------------------	------	--------------

1.	_____	_____	_____
	_____		

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

2.	_____	_____	_____
	_____		

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

3.	_____	_____	_____
	_____		

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

Practitioner's Name \_\_\_\_\_ License# \_\_\_\_\_

Profession \_\_\_\_\_

**IX. LIABILITY CLAIMS**

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. § 63-51-105(a)(5)) YES  NO

If "YES", indicate a brief description of the nature(s) of the claim, the date(s) of the claim report(s), and the amount of the judgment(s), award or settlement(s):

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.	_____	_____
2.	_____	_____
3.	_____	_____

**X. OPTIONAL INFORMATION:**

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-51-105(a)(11))

	TITLE	PUBLICATION	DATE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-51-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. §§ 63-51-113 and/or 63-51-118.

\_\_\_\_\_  
(Signature of Provider) Date: \_\_\_\_\_