EmblemHealth®

55 Water Street, New York, New York 10041-8190

Fax: (866) 593-6986

Hospital Affiliation:

Specialty: _____

License: _____

Primary Hospital: _____

All Current Hospital Affiliations: _____

Are these privileges of the status: Active and/or Admitting? [ ] Yes [ ] No Other_____

Have you ever been denied hospital privileges or have you ever had any hospital privileges revoked, suspended (even if the suspension was stayed), reduced or nonrenewed? [ ] Yes [ ] No

Have you ever voluntarily relinquished or voluntarily limited any hospital privileges? [ ] Yes [ ] No

Have any disciplinary proceedings ever been instituted against you or any disciplinary actions now pending in respect to your hospital privileges or licenses? [ ] Yes [ ] No

If any of the above questions are answered "yes", please explain.

I attest that the information as corrected above is complete and correct to the best of my knowledge and understand that the falsification of this information is grounds for revocation of approval.

Print Name__

Signature _____ Date: _____

Malpractice Coverage
Insurer: _____

Policy Number: _____ Start Date: __/__/____

Coverage Amounts: _____ End Date: __/__/____

I certify that the information as corrected above is complete and correct to the best of my knowledge and understand that the falsification of this information is grounds for revocation of approval. I agree to maintain the types and amounts of malpractice insurance required by HIP and/or GHI Health plans.

Print Name__

Signature _____ Date _____