LIFEGUARD®
COMPLETE CLINICAL CONFIDENCE.

Application for Participation in LifeGuard®

The information provided in this application will be used for the purpose of determining eligibility for the Program and for designing and implementing a program to meet your specific needs.

Note: A $400 non-refundable application fee is required upon submission. Should you choose to enroll in LifeGuard, the application fee will be applied to the overall cost of the Program.

Print Your Name:

_____ _____/_____/_____
Last MI First Date of Birth

List All Previously Used Names:

_____

Address:

_____

Email: _____

Telephone: _____ (Home) _____ (Office) _____ (Cell)

How were you referred to LifeGuard? _____

If referred by State, please attach a copy of Order from the Board.

Contact name at referring Board: _____

Phone: _____ Email: _____

Mailing Address: _____

Medical School: ❑ U.S. ❑ Canada ❑ International
Board Certified: ❑ Yes ❑ No Specialty: _____

Original Cert Date: ____/_____/_____ Recert Date: ____/_____/_____

Board: _____

In what year were you first licensed? _____

In what state(s) have you held a license (other than a training license)?

State Name: ____ ❑ Active ❑ Active Retired ❑ Disciplinary ❑ Lapsed **License #** _____
State Name: ____ ❑ Active ❑ Active Retired ❑ Disciplinary ❑ Lapsed **License #** _____
State Name: ____ ❑ Active ❑ Active Retired ❑ Disciplinary ❑ Lapsed **License #** _____

If Other than above, please describe:

_____

In what state are you seeking to obtain a license or have your license reinstated?

State Name: _____ ❑ Obtain ❑ Reinstate

Have you applied to your state medical board for reinstatement of your license (if applicable)? ❑ Yes ❑ No

In what month and year did you stop practicing full time? _____ (Month) _____ (Year)

Did you maintain any part-time practice activities? ❑ Yes ❑ No

If yes, please describe: _____

Please explain the history of your practice activities and the circumstances surrounding the decision to stop practicing:

_____

_____

_____

_____

Did you maintain CE credits during time period you weren't practicing? ❑ Yes ❑ No

Please provide a copy of your current Curriculum Vitae and CE credits.

Please describe your future practice intentions:

_____

_____

_____

_____

Please provide additional comments you feel will be helpful regarding your situation to assist us in determining your eligibility for participation in LifeGuard and in designing the best program possible to meet your specific needs.

_____

_____

_____

_____

CONFIDENTIAL INFORMATION: If you have any "YES" answers to any questions in the sections below, reference the questions on a separate sheet, give full details, and attach.

Have any of the following privileges been or are they currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, placed on probation or placed under other disciplinary action, either voluntarily or involuntarily in this or any other state?

	Yes	No
Medical or professional license		
DEA Registration or Controlled Substance license		
Hospital medical staff membership		
Clinical privileges or other rights on any hospital medical staff		
Employment by any hospital, institution, or the military		
Professional society membership		
Participation in any private, federal, or state health insurance program		
Board Certification		

Have you ever, at any time, or are you currently:

	Yes	No
Under indictment for any crime?		
The subject of an investigation by any private, federal or state health insurance program or state, territory or country licensing board?		
Under audit by a health care agency (i.e., Medicare, Medicaid, or any insurance)?		
The subject of any adverse action reports to a state or healthcare agency? **(Please attach a self-query report from NPDB)**		
Sanctioned by a government program or agency for any reason?		

Have you ever, at any time, either voluntarily or involuntarily:

	Yes	No
Withdrawn your application for medical staff membership at any facility?		
Withdrawn your request for any clinical privileges at any facility?		

Health Status:

	Yes	No
Have you had any health conditions that may affect your ability to practice?		
Are you currently using illegal substances or illegally using substances?		
Do you have any history of impairment (substance, behavioral, or ethical)?		
Are you currently under treatment for mental/behavioral problems or a psychiatric disorder?		
Are you currently participating in a physicians' health program or monitoring program?		
Do you have Parkinson's Disease?		
History of: o Neurological Disease		
o Concussion		
o Brain Injury		
o MS		
o Stroke		
o Other (please describe)		

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Please be sure your application is complete so that it can be processed in a timely manner. All information is vital and necessary to assess your situation.

In addition to answering every question, please be sure you've attached the following requested documents:

- ❑ Current Curriculum Vitae
- ❑ CE credits
- ❑ Self-query report from NPDB
- ❑ Copies of **all** disciplinary orders/letters from **all** state boards
- ❑ If you have "YES" answers to any Confidential Information questions, reference the questions on a separate sheet, give full details, and attach.

Please return to LifeGuard:

Electronically: info@LifeGuardProgram.com

Via U.S. Postal Service: LifeGuard ◆ 777 E. Park Drive ◆ Harrisburg, PA 17111

Via HIPAA-Compliant Fax: (717) 558-7818 Attn: M. Lammando

CONDITIONS OF APPLICATION

BY COMPLETING THIS APPLICATION, I HEREBY:

- Authorize all representatives of LifeGuard and its staff to consult with my prior associates and others who may have information bearing on my professional competence, character, ethical qualifications, and ability to work cooperatively with others; and,

- Consent to the inspections by all representatives of LifeGuard and its staff of all documents that may be material to an evaluation of my qualifications and competence; and,

- Release from liability all representatives of LifeGuard and its staff for acts performed and statements made concerning my credentials and qualifications; and,

- Release from liability any and all individuals and organizations who provide information to LifeGuard and its staff concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges; and,

- Acknowledge that I, as an applicant for participation in LifeGuard, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications for such participation and for resolving any doubts about such qualifications; and,

- Acknowledge that any misstatements in or omissions from this application constitute cause for denial of participation or cause for dismissal from LifeGuard; and,

- Certify that all information given by me to the foregoing questions and statements on this application is true and correct without omissions of any kind.

By typing my name on signature lines in this document, I confirm:

- that I am the applicant named in this application,
- that I understand that I am signing this document electronically,
- that my electronic signature is the legal equivalent to my handwritten signature, and
- that I attest to the statements made in my Application.

Signature: Date:

_____ _____

LifeGuard will treat this application and any information secured in connection herewith in strictest confidence and will employ all reasonable safeguards to protect the Applicant's privacy.

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Application Fee Payment Method

Name: _____

❑ Check Enclosed for: $400 (made payable to **The Foundation of PA Medical Society**)

❑ Credit Card Charge: $400 ❒ VISA ❒ MasterCard ❑ Discover ❑ American Express

Card # | | | | | | | | | | | | | | | | |

Expiration Date: _____ 3-Digit Security Code: _____

Name (as appears on card): _____

Signature: _____

Street Address: _____

_____

Phone: _____

The credit card charge will be itemized as follows on your billing statement:
Foundation of PA Medical Society

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