AcuPlan Hawaii

Oriental Medicine...5,000 years of quality healthcare

MEMBERSHIP APPLICATION

Please type or print legibly. Incomplete or illegible applications may not be considered.

I. PERSONAL INFORMATION

Name ______________________________ Degree(s) ______________
Last First Middle Initial

Residence Address ______________________________
Street City State Zip

Residence Telephone ______________ Social Security No. ______________

II. BUSINESS INFORMATION

Name of Practice ______________________________

Business Address ______________________________
Street City State Zip

Business Telephone ______________ Fax Number ______________ E-mail ______________

Federal ID # ______________ State License # ______________

Number of years in practice ______ Number of years at this location ______ Number of years of practice in Hawaii ______

Secondary Practice (If applicable) ______________________________

Business Address ______________________________
Street City State Zip

Business Telephone ______________ Fax Number ______________

Number of years at this location ________

Previous Practice (If applicable) ______________________________

Business Address ______________________________
Street City State Zip

Business Telephone ______________ Number of years at this location ______________

Associate Acupuncturists working with you: ______________________________
Name Specialty Phone # (if different)

____
Name Specialty Phone # (if different)

Please check one: ___ Corporation ___ Partnership ___ Sole Proprietorship ___ Trust

Office Hours	Primary Office Location	Secondary Location
Monday	______________	______________
Tuesday	______________	______________
Wednesday	______________	______________
Thursday	______________	______________
Friday	______________	______________
Saturday	______________	______________
Sunday	______________	______________

Who presently covers your practice in your absence? ______________________________

Name Specialty Phone #

NCCA Certification: ☐ Yes ☐ No Expiration Date ______________

Professional Affiliations

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Professional Specialty other than Acupuncture/Oriental Medicine (e.g., Naturopathy, Chiropractic, Massage) ______________

____

Give professional background in the following:

Teaching ______________________________

Research ______________________________

Appointments ______________________________

Honors ______________________________

Publications ______________________________

Panels ______________________________

Elected Positions ______________________________

III. EDUCATIONAL INFORMATION

College (non-acupuncture) ______________________ Years attended______ Degree ______________

College (non-acupuncture) ______________________ Years attended______ Degree ______________

Post-Graduate Education/Training

Name of Course	Location	Date/Year	Certification

IV. PROFESSIONAL LIABILITY COVERAGE

Carrier ____

Address ____
Street City State Zip

Telephone # ______________________ Policy # ______________

Effective From __________ to __________ Coverage Limits ______________ / ______________
per occurrence aggregate

*(Minimum Requirement: 1,000,000/1,000,000)

☐ Yes ☐ No Have you ever been denied professional liability insurance?

☐ Yes ☐ No Have any malpractice claims been filed against you within the last ten years?

☐ Yes ☐ No Are any claims pending?

☐ Yes ☐ No Has any malpractice claim settlement ever been paid by you or on your behalf?

☐ Yes ☐ No Have you ever been disciplined by any State Board?

☐ Yes ☐ No Has your acupuncture license ever been revoked, suspended, or subject to probation or any disciplinary actions or limitations?

☐ Yes ☐ No Have you ever been denied membership or renewal thereof in any acupuncture organization(s)?

☐ Yes ☐ No Has your participation with any HMO or PPO ever been involuntarily terminated?

☐ Yes ☐ No Do you have any financial interest in any health care facility, institution, or organization other than your own private office?

☐ Yes ☐ No Is your physical, emotional, or mental health such that it may impair your ability to provide professional acupuncture services to members of health care plans contracting with AcuPlan Hawaii?

☐ Yes ☐ No Are you now being treated for alcoholism or drug addiction?

NOTE: If any of the answers above are "YES", provide a complete explanation on a separate sheet.

Professional Ethics and Fitness to Practice

Legal Status: You must furnish additional information with this application if you answer "yes" to any of the following questions. This documentation must include your explanation of the charges or claims made against you, all legal documents related to the charges or claims and an account of how the charges or claims were resolved. If a case is still pending, please indicate that fact in your response. This information will be held in confidence by the Board of Directors who evaluate and approve candidate applications.

Have you been a defendant in litigation related to the practice of a health-related profession?	Yes	No
Has a judgment ever been entered against you or have you been a party to a settlement in any legal proceeding related to the practice of a healthcare profession?	Yes	No
Have you ever been convicted of any type of a felony or misdemeanor related to the practice of a health-related profession?	Yes	No
Have you ever been convicted of any other crime or are you on probation or parole?	Yes	No
Have you ever had any disciplinary or administrative actions taken against you by any licensing board or health-related professional association or school?	Yes	No
Have you ever been denied or voluntarily surrendered a license to practice in any health-related profession?	Yes	No

V. PRACTICE INFORMATION

Are you a member in a professional acupuncture association? ☐ Yes ☐ No

Which one(s)? ____________________

Do you have licenses to practice acupuncture in other states? ☐ Yes ☐ No Where? ____________________

Do you treat: ☐ Alcohol addiction ☐ Drug Addiction ☐ H.I.V. Infection

Do you use disposable needles? ☐ Yes ☐ No

Foreign languages spoken by applicant: ____________________

Foreign languages spoken by staff: ____________________

Do you currently use informed consent? ☐ Yes ☐ No

Do you bill insurance? ☐ Yes ☐ No

Services:	In-Office	Referral	Not Available		In-Office	Referral	Not Available
Indirect Moxibustion	___	___	___	Gua Sha	___	___	___
Direct Moxibustion	___	___	___	Heat	___	___	___
Electro-Stimulation	___	___	___	Cold	___	___	___
Herbal Medicine	___	___	___	Ultrasound	___	___	___
Auricular Therapy	___	___	___	Applied Kinesiology	___	___	___
Cupping	___	___	___	Exercise Instruction	___	___	___
Massage/Tuina	___	___	___	Nutrition Counseling	___	___	___
Cold Laser	___	___	___				
Blood Letting	___	___	___	Other ____________________			
Homeopathy	___	___	___	Other ____________________			

VI. REFERENCES

Please list the names, addresses, and telephone numbers of two acupuncturists (who are not in partnership or other contractual arrangement with you) who have direct knowledge of your training and experience and who can speak authoritatively regarding your professional qualifications.

1. ____________________
Name Address Phone #

2. ____________________
Name Address Phone #

AUTHORIZATION TO CREDENTIAL

By my signature below, I certify that the information given by me in this application form is correct and truthful to the best of my knowledge. I authorize AcuPlan Hawaii or its appointed agent(s) to proceed with the necessary credentialing process, which includes verifying the information supplied by me. I agree to inform AcuPlan Hawaii promptly if any material change of such information occurs. I understand that intentional omissions and false or misleading statements may be grounds for exclusion from membership in AcuPlan Hawaii.

Signature

Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I consent to the release of information by any governmental agency, databank, practice group, individual, or entity to AcuPlan Hawaii for the purpose of proper evaluation of my professional status and qualifications, as well as personal competence, character, and ethics. I release from liability and hold harmless any person or entity furnishing such information. I understand and agree that I, as an applicant for membership in AcuPlan Hawaii, have the burden of producing adequate information for proper evaluation as necessary for credentialing, resolving any doubts about my professional and personal qualifications, character, and competence.

Signature

Date