



Managed Mental Health Care Organization for Coos, Curry, Douglas, Jackson, Josephine, and Klamath Counties
 900 SE 8th Street, Suite 100, Grants Pass, Oregon 97526 • Phone: 541-955-9565 • Fax: 541-955-8290

CLINICAL STAFF DISCLOSURE FORM

IDENTIFYING INFORMATION

Name: _____

Agency Name: _____

Primary Office Address: _____

Main Phone Number: _____

Fax Number: _____

STAFF LIABILITY EXPERIENCE AND ADVERSE ACTIONS

LIABILITY EXPERIENCE

If you answer "yes" to any the following questions, please provide specific information on a separate sheet and include information on the ***date, claim initiated, nature of claim, names of parties, name and location of court, description of status or disposition for claims.***

Liability Experience	Yes	No
Have there ever been or are there currently pending any malpractice claims, settlements, judgments or arbitration proceedings involving professional practice?	<input type="checkbox"/>	<input type="checkbox"/>
Has professional liability coverage ever been terminated by the carrier?	<input type="checkbox"/>	<input type="checkbox"/>
Has professional liability coverage ever been denied?	<input type="checkbox"/>	<input type="checkbox"/>
Has the carrier ever excluded any specific procedure or practice from the coverage?	<input type="checkbox"/>	<input type="checkbox"/>

ADVERSE ACTIONS

Have any of the following ever been or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily or involuntarily relinquished, or have you ever withdrawn or failed to proceed with an application for any of the following? *If yes, please provide a full explanation on a separate sheet.*

Adverse Actions	Yes	No
Professional registration/ license in any state?	<input type="checkbox"/>	<input type="checkbox"/>
DEA/controlled substance registration?	<input type="checkbox"/>	<input type="checkbox"/>
Any other type of professional sanction?	<input type="checkbox"/>	<input type="checkbox"/>
Membership, clinical privileges or prerogatives/right on any hospital medical staff?	<input type="checkbox"/>	<input type="checkbox"/>
Professional society membership or fellowship certification?	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid or Medicare provider status?	<input type="checkbox"/>	<input type="checkbox"/>
To your knowledge have you ever been the subject of an individual focused review required by a peer review agency?	<input type="checkbox"/>	<input type="checkbox"/>
Convictions for criminal or drug and alcohol charges.	<input type="checkbox"/>	<input type="checkbox"/>

CERTIFICATION OF INFORMATION

I understand that my application for membership in the Jefferson Behavioral Health network may require a thorough review of information regarding past or present status with any licensing Boards or professional organizations and malpractice insurers. I hereby authorize release of all such information and understand that all such information will be reviewed in strict confidence to the degree permitted by law. No information obtained or reviewed will be re-released without additional consent in writing. This information will be subject to the same privacy protections given employees of their respective employer.

I understand that any information received about this application will be available for my review and comment at any time I may so request. This release will remain in effect throughout the duration of my membership with JBH, or until canceled in writing.

All information submitted in this application is true to my best knowledge and belief. I fully understand that any significant misstatement in or omission from this application as well as any change in, or failure to inform JBH of any changes in, information provided on this application, may constitute cause for denial of participation or cause for dismissal from JBH.

Staff Signature _____ Date _____