NORTHERN LIGHT HEALTH
THRESHOLD ELIGIBILITY CRITERIA FOR APPOINTMENT, REAPPOINTMENT AND CLINICAL PRIVILEGES

To be eligible to apply for initial appointment, reappointment, and clinical privileges, an individual must demonstrate satisfaction of all of the following:

- ☐ **Current**, unrestricted license to practice in Maine that is not subject to any restrictions, conditions, or probationary terms and have never had a license to practice in any jurisdiction denied, revoked, restricted or suspended for more than 30 days by any state licensing agency.

- ☐ Not currently be under investigation by any federal or state agency or healthcare facility for reasons related to (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud (including Medicare, Medicaid or other federal or state governmental or private third-party payer fraud or program abuse); (iv) violent acts; (v) sexual misconduct; (vi) moral turpitude; or (vii) child or elder abuse.

- ☐ **Current**, unrestricted DEA registration and the appropriate state-controlled substance license, and have never had a DEA registration or state-controlled substance license denied, revoked, or suspended.

- ☐ Be located (office and residence) close enough to fulfill Medical Staff responsibilities and to provide timely and continuous care for his or her patients in the Hospital

- ☐ Consistent with the Professional Liability Insurance Limits Policy, have current, valid professional liability insurance coverage in compliance with state law, covering all clinical privileges requested and meeting all requirements of that policy.

- ☐ **Current**, government-issued photographic identification which verifies the individual's identity

- ☐ **Successfully completed** the following applicable professional training requirements:
  - ☐ a residency and, if applicable, fellowship training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in the specialty in which the applicant seeks clinical privileges;
    Graduates of foreign medical schools must successfully complete the examination of the Education Commission for Foreign Medical Graduates (ECFMG) or of the National Board of Medical Examiners or their successors; and must satisfactorily complete at least thirty-six (36) months in an internship/residency/fellowship program(s),which is accredited by the Accreditation Council on Graduate Medical Education (ACGME), the Canadian Medical Association, or the Royal Colleges of Physicians of England, Ireland or Scotland or has satisfactorily graduated from a combined postgraduate training program in which each of the contributing programs is accredited by the ACGME and is eligible for accreditation by the American Board of Medical Specialties (ABMS) in both specialties or is board certified by the ABMS; or
  - ☐ a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association.
  - ☐ a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association.
  - ☐ for advanced practice professionals, and allied health providers, have satisfied the applicable training requirements as established by the Hospital.

- ☐ Satisfy the following board certification requirements:
  - ☐ are certified in their primary area of practice at the Hospital by an approved board as defined in this Policy, or
  - ☐ are within five years of completion of residency or fellowship training with the exception of identified sub-specialists who can be given up to 7 years to allow the necessary time to accrue sufficient clinical volume/experience as deemed by the applicable local Clinical Service Chief and achieve board certification in their primary area of practice within this applicable timeframe from the date of completion of their residency or fellowship training; and
  - ☐ maintain board certification in their primary area of practice at the Hospital on a continuous basis, and satisfy all requirements of the relevant specialty/subspecialty board necessary to do so;

If a new board certification is established in a specialty/subspecialty, and is directly relevant to their primary area of practice, the timeframe for testing and board certification will be based on the recommendation of that Board.

Satisfy the following professional practice and experience requirements:

- ☐ demonstrate recent clinical activity in their primary area of practice, in an acute care hospital, during the last two years
- ☐ have never had staff appointment, clinical privileges, or status as a participating provider denied, revoked, suspended for more than 30 days, or terminated by any health care facility, including the Hospital, or health plan for reasons related to clinical competence or professional conduct
- ☐ have never resigned staff appointment or relinquished clinical privileges during an investigation or in exchange for not conducting such an investigation at any health care facility, including any member organization
- ☐ have never had an application for appointment or clinical privileges not processed, nor had appointment or privileges administratively relinquished, at the Hospital or any member organization, due to an omission or misrepresentation
- ☐ have never been terminated from a post-graduate training program for reasons related to clinical competence or professional conduct (residency or fellowship for physicians or a similarly equivalent program for other categories of practitioners), nor resigned from such a program during an investigation or in exchange for the program not conducting an investigation
- ☐ not currently be under any criminal investigation or indictment and have not, within the last five years, been convicted of, or entered a plea of guilty or no contest to, any felony, or to any misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud or abuse; (iv) violent acts; (v) sexual misconduct; (vi) moral turpitude; or (vii) child or elder abuse
- ☐ have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program

- ☐ Satisfy the following Hospital practice requirements:
    - ☐ meet any current or future eligibility requirements that are applicable to the clinical privileges being sought or granted;
    - ☐ if applying for privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in that contract;
    - ☐ have an appropriate coverage arrangement with another member with appropriate specialty-specific privileges as determined by the Credentials Committee and the Medical Executive Committee, for those times when the individual will be unavailable;
    - ☐ document compliance with all applicable training, educational and practice protocols that may be adopted by the Medical Executive Committee and required by the Board, including, but not limited to, those involving electronic medical records, computerized physician order entry, privacy and security of protected health information, infection prevention, and patient safety;
    - ☐ agree to fulfill all responsibilities regarding call for their specialty; as determined by each member hospital appropriate medical staff clinical service chief in alignment with their local rules and regulations;
    - ☐ document compliance with health screening requirements (i.e., TB testing, mandatory flu vaccines, and infectious agent exposures);

- ☐ if seeking to practice as an advanced practice professional, or allied health provider, have a written agreement, as may be required, with a collaborating physician, which meets any state and Hospital policy standards.

Application Checklist for
The Maine Uniform Application for Initial Appointment

Before submitting your application, please take a minute to review this checklist to ensure the application is complete.

Signature on pages 11 and 14 **must** be original and must have a current date.

Essential facts about any pending or closed malpractice suit(s) must be included. Use the Malpractice Claims/Suit History form which is Page 11. If none, so indicate on the Malpractice Claims/Suit History form, sign and date.

Most healthcare organizations in Maine require the following documents be attached to your application, if not previously provided:

- ✓ Copy of current Curriculum Vitae
- ✓ Copies of all current healthcare licenses
- ✓ Face sheet of current malpractice policy showing policy limits, expiration date and your name as an insured provider
- ✓ Copy of Maine DEA registration, if applicable
- ✓ Copies of Board certificates
- ✓ Copies of Malpractice Insurance certificates
- ✓ Certified copy of change of name document, if applicable
- ✓ Copy of any current Life Support certificates (i.e., BLS, ACLS, ATLS, PALS or NRP)
- ✓ Original passport sized photograph. This photo may be sent to references or current hospital(s) for identification
- ✓ For NPs under delegation and PAs – Copy of the Registration of Physician Extender and current Plan of Supervision. The Plan of Supervision must be specific to the healthcare facility to which you are applying. Please provide a Plan of Supervision for each position you hold. Please check with the healthcare facility(s) to which you are applying to confirm whether there are additional requirements for supervision.

Please check with each facility and/or managed care organization to which you are applying to determine if any additional documents are required.

The Maine Uniform Application for Initial Appointment

It is the responsibility of the applicant to notify the facility of all changes to address, e-mail, phone, etc.

SECTION I – PERSONAL INFORMATION

Last Name: Carter First Name: Emily Middle Name: R.

Suffix (Jr., II, etc.): _____ Professional Title/Degree: MD Gender: Male ☐ Female ☐

Name used when degree obtained/Any other surname used: _____

Social Security Number: _____ Date of Birth: _____

Place of Birth: City/State or Country: _____ Citizenship: _____

ECFMG number (If applicable): _____

Date: _____

If not a US Citizen, are you eligible to work lawfully in the United States? Yes ☐ No ☐

Do you hold a: J1 ☐ H1B ☐ Green Card ☐

MILITARY SERVICE: Yes ☐ No ☐

Branch of Service: _____

Last Duty Station: _____

Please provide a copy of DD214, if applicable.

Are you a member of the reserves? Yes ☐ No ☐

Reserve Branch: _____

Home Address: _____

City/State/Zip: _____ Phone: _____ Home ☐ Cell ☐

Current E-Mail Address (Required): _____

CAQH#: _____ NPI#: 1,234,567,890

SECTION II – LOCAL AREA INFORMATION

Name of Practice/Hospital that you will be joining: _____ Expected Start Date: _____

PRIMARY OFFICE LOCATION/ANTICIPATED OFFICE LOCATION

Office or Group Name: _____

Street and/or PO Box: 100 Main Street, Suite 200 City/State/Zip: Brunswick, ME 04011

Phone: _____ Fax: _____ Email: _____

Office Manager: _____ Phone / Email: _____

Credentialing Contact: _____ Phone / Email: _____

Applicant Name: Emily R. Carter, MD

SECTION II – LOCAL AREA INFORMATION

OTHER OFFICE LOCATIONS:

Office or Group Name: _____

Street and/or PO Box: 100 Main Street, Suite 200 City/State/Zip: Brunswick, ME 04011

Phone: _____ Fax: _____ Email: _____

Office Manager: _____ Phone / Email: _____

Credentialing Contact: _____ Phone / Email: _____

Office or Group Name: _____

Street and/or PO Box: _____ City/State/Zip: _____

Phone: _____ Fax: _____ Email: _____

Office Manager: _____ Phone / Email: _____

Credentialing Contact: _____ Phone / Email: _____

Office or Group Name: _____

Street and/or PO Box: _____ City/State/Zip: _____

Phone: _____ Fax: _____ Email: _____

Office Manager: _____ Phone / Email: _____

Credentialing Contact: _____ Phone / Email: _____

SECTION III - EDUCATION PLEASE LIST IN CHRONOLOGICAL ORDER DO NOT "REFER TO ATTACHED CV"

(Post Graduate Training is on the next page.)

UNDERGRADUATE EDUCATION

College/University: _____ Degree Awarded: _____

Address: _____

City/State/Zip Country

Dates Attended: From: _____ to: _____ Graduation Date: _____

PROFESSIONAL/GRADUATE EDUCATION

College/University: Tufts University School of Medicine Degree Awarded: M.D.

Address: _____

City/State/Zip Country

Dates Attended: From: _____ to: _____ Graduation Date: 05/15/2019

Applicant Name: Emily R. Carter, MD

SECTION III - EDUCATION PLEASE LIST IN CHRONOLOGICAL ORDER DO NOT "REFER TO ATTACHED CV"

PROFESSIONAL/GRADUATE EDUCATION

College/University: Tufts University School of Medicine Degree Awarded: _____

Address: _____
City/State/Zip Country

Dates Attended: From:_____ to:_____ Graduation Date: 05/15/2019

PROFESSIONAL/GRADUATE EDUCATION

College/University: _____ Degree Awarded: _____

Address: _____
City/State/Zip Country

Dates Attended: From:_____ to: _____ Graduation Date: 06/30/2022

PROFESSIONAL/GRADUATE EDUCATION

College/University: _____ Degree Awarded: _____

Address: _____
City/State/Zip Country

Dates Attended: From:_____ to: _____ Graduation Date: _____

POST GRADUATE TRAINING Please provide an explanation for any GAPS greater than 60 days

INTERNSHIP

Institution: _____

Address: _____
City/State/Zip

Dates Attended (Mo/Yr): From:_____ to: _____ Specialty _____

Program Director:

Name: _____ Degree: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

Applicant Name: Emily R. Carter, MD

POST GRADUATE TRAINING Please provide an explanation for any GAPS greater than 60 days

RESIDENCIES

Institution: Maine Medical Center - Family Medicine Residency

Address: _____
City/State/Zip

Dates Attended (Mo/Yr): From: _____ to: 06/30/2022 Specialty: Family Medicine

Program Director:

Name: _____ Degree: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

Institution: _____

Address: _____
City/State/Zip

Dates Attended (Mo/Yr): From: _____ to: _____ Specialty: _____

Program Director:

Name: _____ Degree: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

FELLOWSHIPS

Institution: _____

Address: _____
City/State/Zip

Dates Attended (Mo/Yr): From: _____ to: _____ Specialty: _____

Program Director:

Name: _____ Degree: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

***For additional fellowship information please use the space on below or attach a separate sheet of paper.**

Applicant Name: Emily R. Carter, MD

Specialty Designation:

Primary (in which you spend 50% or more of your time): Family Medicine

Certification Number_____ Certification Date: _____ Expiration Date: _____

Specialty Board: _____

Lifetime Yes ☐ No ☐

Secondary: _____

Certification Number_____ Certification Date: _____ Expiration Date: _____

Specialty Board: _____

Lifetime Yes ☐ No ☐

Other Specialty: _____

Certification Number_____ Certification Date: _____ Expiration Date: _____

Specialty Board: _____

Lifetime Yes ☐ No ☐

Other Specialty: _____

Certification Number_____ Certification Date: _____ Expiration Date: _____

Specialty Board: _____

Lifetime Yes ☐ No ☐

Do you have clinical privileges at any hospital in the specialty noted? Yes ☐ No ☐

Maintenance of Certification

Required to participate in MOC? Yes ☐ No ☐ Participating in MOC? Yes ☐ No ☐

If you are not currently Board certified are you pursuing certification? Yes ☐ No ☐

If 'Yes', name of Board: _____

Expected date of completion: _____

If 'No', do you have postgraduate training sufficient to meet the requirements of a specialty board? Yes ☐ No ☐

Please explain the reason(s) for not pursuing certification, including any unsuccessful attempts_____

_____

_____

_____

Applicant Name: Emily R. Carter, MD

SECTION V – HOSPITAL AFFILIATIONS DO NOT "REFER TO ATTACHED CV"

List CHRONOLOGICALLY (most recent first) all current and previous hospitals where you hold or have held medical staff membership and/or clinical privileges, for the past ten (10) years, beginning with your current PRIMARY hospital. Please provide an explanation of any gaps greater than 60 days. If additional space is required, please use page 14 or a separate sheet of paper. You may submit your certificates of insurance for EACH location.

Institution: Maine Medical Center - Family Medicine Residency

Address: ______ City/State/Zip: ______

Phone: ______ Fax: ______ Position/Staff Category: Resident Physician

Department/Service: Family Medicine Department Chief: ______

Dates at this institution: From: ______ to: 06/30/2022

Institution: ______

Address: ______ City/State/Zip: ______

Phone: ______ Fax: ______ Position/Staff Category: ______

Department/Service: ______ Department Chief: ______

Dates at this institution: From: ______ to: ______

Institution: ______

Address: ______ City/State/Zip: ______

Phone: ______ Fax: ______ Position/Staff Category: ______

Department/Service: ______ Department Chief: ______

Dates at this institution: From: ______ to: ______

Institution: ______

Address: ______ City/State/Zip: ______

Phone: ______ Fax: ______ Position/Staff Category: ______

Department/Service: ______ Department Chief: ______

Dates at this institution: From: ______ to: ______

Institution: ______

Address: ______ City/State/Zip: ______

Phone: ______ Fax: ______ Position/Staff Category: ______

Department/Service: ______ Department Chief: ______

Dates at this institution: From: ______ to: ______

Applicant Name: Emily R. Carter, MD

Please list CHRONOLOGICALLY (since completing training) all professional activities, paid or volunteer, self-employment, service as an independent contractor (including Locums agencies), and/or any healthcare entities OTHER THAN THE HOSPITALS listed on pages 1 and 2. If you need additional space, please use page 14 or a separate piece of paper. You may submit your certificates of insurance for EACH location.

ANY GAP OF GREATER THAN 60 DAYS IN CHRONOLOGY REQUIRES EXPLANATION ON A SEPARATE PAGE.

Name of Organization: ______________________________
Address: ______________________________ City/State/Zip: ______________________________
Contact Name: ______________________________
Phone: ____________ **Fax**: ____________ **Email**: ______________________________
Your position held/Title: ______________________________ Dates: From: ____________ to: ____________

Name of Organization: ______________________________
Address: ______________________________ City/State/Zip: ______________________________
Contact Name: ______________________________
Phone: ____________ **Fax**: ____________ **Email**: ______________________________
Your position held/Title: ______________________________ Dates: From: ____________ to: ____________

Name of Organization: ______________________________
Address: ______________________________ City/State/Zip: ______________________________
Contact Name: ______________________________
Phone: ____________ **Fax**: ____________ **Email**: ______________________________
Your position held/Title: ______________________________ Dates: From: ____________ to: ____________

Name of Organization: ______________________________
Address: ______________________________ City/State/Zip: ______________________________
Contact Name: ______________________________
Phone: ____________ **Fax**: ____________ **Email**: ______________________________
Your position held/Title: ______________________________ Dates: From: ____________ to: ____________

Applicant Name: Emily R. Carter, MD

SECTION VIII – LICENSING LIST ALL CURRENT AND PAST LICENSES

State	Type	License Number	Date Issued	Expiration Date	Status
Maine	Medical License	MED12345	07/01/2025	06/30/2027	Active

1. Have you **ever** had your license to practice medicine in any state or other jurisdiction involuntarily or voluntarily restricted, suspended, revoked, denied, made subject to probationary conditions, or otherwise disciplined?	Yes ☐ No ■
2. Are there any proceedings which could result in such action **currently** pending?	Yes ☐ No ■
3. Have you **ever** voluntarily withdrawn an application for licensure, resigned your license or permitted it to lapse?	Yes ☐ No ■

***If the answer is "YES" to any of the above questions, please provide details on Page 1п or a separate sheet of paper.**

DEA REGISTRATION

Federal DEA Registration Number	Date Issued	Expiration Date
EC9876543		

4. Have you **ever** been denied registration by the U.S. Drug Enforcement Administration (DEA) or has your registration ever been modified, restricted, suspended or revoked?	Yes ☐ No ■
5. Have you **ever** been denied registration by any state to prescribe or dispense controlled substances or has your registration ever been modified, restricted, suspended or revoked?	Yes ☐ No ■
6. Are there any proceedings which could result in such action **currently** pending?	Yes ☐ No ☐
7. Have you **ever** voluntarily withdrawn your narcotics application, resigned your registration or permitted it to lapse?	Yes ☐ No ■

***If the answer is "YES" to any of the above questions, please provide details on Page 1п or a separate sheet of paper.**

Applicant Name: Emily R. Carter, MD

SECTION VII – INSURANCE CARRIERS LIST CHRONOLOGICALLY (Current carrier first)

Please include ALL insurance companies for the last ten (10) years, or if applicable since internship, that have provided professional liability coverage. If you require additional space, please use Page 14 or a separate sheet of paper.

ANY GAP IN COVERAGE REQUIRES EXPLANATION ON A SEPARATE PAGE.

Primary Insurance Carrier: Medical Mutual Insurance Company of Maine

Address: _____ City/State/Zip: _____

Institution Affiliation: _____

Phone: _____ Fax: _____ Policy Number: MMICM456789

Date of Coverage (Mo/Yr) From: 07/01/2025 to: 06/30/26 Coverage Amounts (incident/aggregate): 1,000,000 / 3,000,000

Secondary Insurance Carrier: _____

Address: _____ City/State/Zip: _____

Institution Affiliation: _____

Phone: _____ Fax: _____ Policy Number: _____

Date of Coverage (Mo/Yr) From: _____ to: _____ Coverage Amounts (incident/aggregate): _____

Prior Insurance Carrier: Medical Mutual Insurance Company of Maine

Address: _____ City/State/Zip: _____

Institution Affiliation: _____

Phone: _____ Fax: _____ Policy Number: MMICM456789

Date of Coverage (Mo/Yr) From: 07/01/2025 to: 06/30/26 Coverage Amounts (incident/aggregate): 1,000,000 / 3,000,000

Prior Insurance Carrier: _____

Address: _____ City/State/Zip: _____

Institution Affiliation: _____

Phone: _____ Fax: _____ Policy Number: _____

Date of Coverage (Mo/Yr) From: _____ to: _____ Coverage Amounts (incident/aggregate): _____

Applicant Name: Emily R. Carter, MD

8. Have you **ever** practiced medicine without liability coverage?	Yes ☐ No ■
9. Have you **ever** been denied professional liability insurance or has your policy ever been canceled or denied renewal?	Yes ☐ No ☐
10. Have any restrictions **ever** been placed on your liability insurance?	Yes ☐ No ☐
11. Have you **ever** had an insurance carrier add a surcharge to your malpractice policy or increase your deductible?	Yes ☐ No ☐

***If the answer is "Yes" to any of the above questions, please complete a Malpractice Claims/Suit History (page 1M) for each event.**

12. Have you ***ever*** received a notice of claim* or been a defendant in a medical malpractice suit arising out of or in connection with your individual professional services? *Notice of claim is defined as a written communication from a claimant or plaintiff setting forth an allegation of professional malpractice, threatening or initiating legal action, and demanding monetary damages.	Yes ☐ No ☐
13. Are you aware of any such notice of claims against another person or entity rising out of or in connection with your individual professional services?	Yes ☐ No ☐
14. Have **ever** you or your malpractice carrier or any other person or entity made an out-of-court settlement or paid a judgment on a professional liability claim on your behalf or on behalf of any other person or entity rising out of or in connection with your individual professional services in the past 10 years?	Yes ☐ No ■

Applicant Name: Emily R. Carter, MD

MALPRACTICE CLAIMS/SUIT HISTORY

PLEASE COPY THIS FORM FOR EACH ADDITIONAL CLAIM/SUIT FOR ALL CASES YOU HAVE EVER BEEN NAMED IN

NO CLAIMS: ☐ PLEASE SIGN AND DATE AT BOTTOM

Date of Alleged Incident: _____ Date Lawsuit Filed: _____

Carrier at Time of Alleged Incident: _____

Name of Court and Case Number: _____

Please explain the nature of allegations of wrongdoing/negligence:

Status of Case: (with reference to you specifically)

- ☐ Notice of Claim Filed: Date as of _____
- ☐ Pending before malpractice panel: Date as of _____
- ☐ Pending in court: Date as of _____
- ☐ Closed without payment: Date _____
- ☐ Pre-Trial Settlement: $_____Date as of _____
- ☐ Verdict for Defendant: Date as of _____
- ☐ Verdict for Plaintiff: $_____Date as of _____

What was/is your status?

- ☐ Sole Defendant_____
- ☐ Co-Defendant with: _____
- ☐ Other: _____

I understand information submitted herein becomes part of my Application for staff appointment/credentialing and may also be used in future credentialing.

Signature: _____ **Date:** 03/10/2026

Applicant Name: Emily R. Carter, MD

SECTION IX – REFERENCES

Please provide names and complete addresses of four (4) professional references.

- These individuals must have personal knowledge, over the past **24-month period**, of your current clinical skills, ability, ethical character, judgment, professional performance, and clinical competence or have been responsible for professional observation of your work.
- References may not be provided by relatives, current classmates, spouse or domestic partner.
- Acceptable references include referring physicians or professional peers – defined as being in the same professional discipline with equal qualifications. (MD/DO – MD/DO; DMD/DDS –DMD/DDS; PA/NP – PA/NP, etc.)
- References should be individuals other than your business partners or associates, if possible.
- If you currently hold hospital privileges, one reference must be your current department chief.
- If you are currently completing a residency or fellowship, one reference must be the program director.

Advanced Practice Provider's (APP's) MUST provide at least one MD/DO.

Current Department Chief or Residency/Fellowship Director

First Name: ______________ Last Name: ______________ Degree: ________

Specialty: ______________ **Email** (required): ______________

Phone: ______________ **Fax** (required): ______________

Address: ______________ City/State/Zip: ______________

In what capacity has this individual observed your clinical abilities? ______________

First Name: ______________ Last Name: ______________ Degree: ________

Specialty: ______________ **Email** (required): ______________

Phone: ______________ **Fax** (required): ______________

Address: ______________ City/State/Zip: ______________

In what capacity has this individual observed your clinical abilities? ______________

First Name: ______________ Last Name: ______________ Degree: ________

Specialty: ______________ **Email** (required): ______________

Phone: ______________ **Fax** (required): ______________

Address: ______________ City/State/Zip: ______________

In what capacity has this individual observed your clinical abilities? ______________

First Name: ______________ Last Name: ______________ Degree: ________

Specialty: ______________ **Email** (required): ______________

Phone: ______________ **Fax** (required): ______________

Address: ______________ City/State/Zip: ______________

In what capacity has this individual observed your clinical abilities? ______________

Applicant Name: Emily R. Carter, MD

SECTION X - REQUIRED QUESTIONS

If the answer is "YES" to any of the following questions, please explain and include a copy of any order or settlement where applicable. ALL QUESTIONS MUST BE ANSWERED.

15. Have you **ever** had your clinical privileges or employment at any hospital or any other health care facility limited or restricted, suspended, revoked, withdrawn involuntarily, involuntarily not renewed or made subject to probationary conditions or otherwise adversely affected or are there such proceedings **currently** pending?	Yes ☐ No ■
16. Have you **ever** had a request for any specific clinical privilege(s) denied as a result of disciplinary action or granted only with stated limitations (aside from ordinary initial probationary requirements of proctorship) or are there such proceedings **currently** pending? *For purposes of this question, voluntary withdrawal does not constitute denial.	Yes ☐ No ■
17. Have you **ever** withdrawn an application to any healthcare entity? If yes, the name of the entity _____	Yes ☐ No ■
18. Have you **ever** voluntarily not renewed, surrendered or modified your privileges or resigned from medical staff membership? *For purposes of this question, moving out of state, end of contract denotes an affirmative response.	Yes ☐ No ■
19. Have you **ever** had your medical staff membership or status on the staff of any hospital or other health care facility limited, denied, suspended, revoked, not renewed or made subject to probationary conditions or otherwise adversely affected or are there such proceedings **currently** pending?	Yes ☐ No ■
20. Is there currently pending against you any litigation, investigatory or disciplinary proceeding with respect to privileges, licensure, DEA or other criminal or administrative matter (including Medicare, Medicaid or Quality Improvement Organization (QIO) sanctions) or civil matter initiated by the government?	Yes ☐ No ■
21. Have you **ever** been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation or otherwise sanctioned, by any health care organization, including but not limited to, hospitals, or other health care facilities, based on professional competence?	Yes ☐ No ☐
22. Have you **ever** been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation or otherwise sanctioned by HMOs, PPOs, PHOs, independent practitioner associations (IPA) professional associations or societies, professional standards review organizations (PSRO) or peer review organizations (QIO) based on professional competence?	Yes ☐ No ■
23. Have you **ever** been excluded, suspended, or otherwise sanctioned by Medicare or Medicaid or are there such proceedings **currently** pending?	Yes ☐ No ■
24. Have you **ever** been disciplined by a professional society or resigned while allegations were pending?	Yes ☐ No ■
25. Have you **ever** been convicted in a criminal proceeding or been subject to an adverse government agency administrative decision (including QIO, Medicare and/or Medicaid sanctions), been subject to an adverse decision in any civil litigation brought by a government agency, entered a plea of nolo contendere, or been subject to an adverse settlement in any such proceeding?	Yes ☐ No ■
26. Have you **ever** been convicted of any criminal offense (including motor vehicle offenses but not including minor traffic or parking violation) or are there any such proceedings **currently** pending?	Yes ☐ No ■
27. Are you currently engaged in the illegal use of drugs?	Yes ☐ No ■
28. Have you been found guilty in a proceeding investigating substance abuse?	Yes ☐ No ■

Applicant Name: Emily R. Carter, MD

SECTION X - REQUIRED QUESTIONS CONTINUED

Your application will be processed in the usual manner regardless of how you answer questions 29 and 30 below. If you have answered "NO" to questions 29 or 30, please explain completely, using a separate sheet of paper if necessary. If you are found to be qualified, a representative will contact you to determine what accommodations are necessary and feasible to allow you to practice safely.

29. Are you physically and mentally able to perform all the essential functions or services necessary to exercise the privileges or services applied for with or without reasonable accommodations?	Yes ☐ No ☐
30. Are you able to perform these functions without significant risk or injury to yourself or others?	Yes ☐ No ☐

Signature of Applicant: _____ **Date:** 03/10/2026

Please use this space for additional information and explanations (including any gaps in training, work history, insurance coverage, or hospital affiliations). A separate sheet of paper may be used.

Applicant: Emily R. Carter, MD. Application Type: Initial Appointment. Specialty: Family Medicine. NPI: 1234567890. DEA: EC9876543. Maine Medical License: MED12345 (Issue Date: 07/01/2025; Expiration Date: 06/30/2027). Primary Practice Address: 100 Main Street, Suite 200, Brunswick, ME 04011. Education/Training: Tufts University School of Medicine (Graduation: 05/15/2019); Maine Medical Center – Family Medicine Residency (Completion: 06/30/2022). Professional Liability Insurance: Medical Mutual Insurance Company of Maine, Policy #MMICM456789, Coverage $1,000,000 / $3,000,000, Policy Period 07/01/2025 to 06/30/2026. Attestation Questions: all answered " No " . Signature Date: 03/10/2026.

Applicant Name: Emily R. Carter, MD