



**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:**

\_\_\_\_\_

First

MI

Last

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Gender:**  Male  Female

**List All Names Previously Used:** \_\_\_\_\_

**Home Address:**

\_\_\_\_\_

**Business/Office Address:**

\_\_\_\_\_

**Preferred Mailing Address:**  Home Address  Business/Office Address

**Email:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ (Home) \_\_\_\_\_ (Office) \_\_\_\_\_ (Cell)

**How did you hear about LifeGuard?**  Employer  State Medical Board  Medical Society

Colleague  Internet  Other \_\_\_\_\_

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

Contact name at referring Board: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_



Please describe your future practice intentions:

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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.

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**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? <b>(Please attach a self-query report from NPDB)</b>		
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
- Current **full** Self-query report from NPDB (within 6 months of submitting your application)
- 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:**

Via U.S. Postal Service: LifeGuard ♦ 400 Winding Creek Blvd. ♦ Mechanicsburg, PA 17050  
Via HIPAA-Compliant Fax: (855) 943-3361 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.

Signature:

Date:

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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 #

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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"**

**Please return to LifeGuard:**

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