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METHADONE / BUPRENORPHINE SUPPLEMENTAL APPLICATION

(Must be completed by each physician)

1. Physician's Name _____
2. Name of Clinic/Center _____
3. Medical Specialty _____
4. Are you Board Certified? Yes ___ No ___ If no, are you Board Eligible? Yes ___ No ___
5. License Number _____
6. How many hours per week do you work on behalf of the clinic? _____
7. What medical care do you provide at this clinic, other than performing physical exams and administering Methadone and/or Buprenorphine? _____

8. When you are not at this clinic, what are your medical activities/duties? _____

9. Have you ever had a malpractice claim or suit filed against you? Yes ___ No ___
If yes, please explain. _____

10. Have you ever had your license revoked, suspended, restricted, or placed on probation?

Yes _____ No _____ If yes, please explain. _____

11. Have you ever been the subject of an investigatory or disciplinary proceeding or reprimand?

Yes _____ No _____ If yes, please explain. _____

12. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes _____ No _____ If yes, please explain. _____

13. Have you ever been treated for alcoholism or drug addiction?

Yes _____ No _____ If yes, please explain. _____

14. What is the name of your malpractice insurer? (If none, please indicate.) _____

Limit of Liability \$ _____ Effective Date _____ Policy # _____

15. Does your malpractice policy cover you for your acts at the Clinic/Center? Yes _____ No _____

16. Do you prescribe? Methadone _____ Buprenorphine _____ Both _____

17. How many doses did the clinic dispense in the past twelve months?

Methadone _____ Buprenorphine _____

Physician's Signature

Date