

Genesee County Medical Control Authority

Questionnaire for Provider Applicants

Please provide the name, title, mailing address and telephone number of the President or Chief Executive Officer of the provider agency.

Name

Title

Address

City/State/Zip

Telephone

Please provide name, title, mailing address and phone number for an individual designated to speak on behalf of your service. It is understood that the individual who appeals for your service has the authority to answer any and all questions pertinent to your service's operation and application to the Genesee County Medical Control System.

Name

Title

Address

City/State/Zip

Telephone

1. List the name and credentials of the person responsible for the Genesee County operation

2. Please list all medical control areas in which your service has operated within the past three years.

3. Please list all hospitals and hospital phone numbers within the medical control areas you have served within the past three years.

4. Please provide the names and addresses of three professional references that are familiar with your service's operations during the past three years.

5. Has any owner, operator, manager, or employee of the service been convicted of a felony within the past three years?

_____ Yes _____ No

6. Has this service been denied application or the right to operate within a medical control board/authority jurisdiction within the past three years?

_____ Yes _____ No

7. Is the service now or at any time within the past three years received a denial of license, revocation of license, warning or disciplinary action from any state licensing agency?

_____ Yes _____ No

8. Has the service received notice of infraction, warning or disciplinary action from any medical control board/authority within which the service is operated within the past three years?

_____ Yes _____ No

9. Within the past three years has this service been involved in litigation with the state, medical control board/authority, patients, hospitals or other medical service providers?

_____ Yes _____ No

10. Please provide the name and address of all professional organizations and associations with which this service and its management are affiliated.

11. Has this service ever been denied professional liability and/or practice insurance?

_____Yes _____No

12. Has this service ever been denied licensure and/or operating privileges in Michigan or any other state?

_____Yes _____No

13. Has this service within the past three years experienced difficulty working cooperatively with other pre-hospital health care systems, with other providers, hospitals and/or medical personnel?

_____Yes _____No

Any affirmative answer (Yes) to the above questions requires a written, detailed explanation of the circumstances. Attach the explanation to this questionnaire.

APPLICANTS ACKNOWLEDGMENT

I fully understand that any misstatements or omissions from this application constitute cause for denial of application for service in the Genesee County Medical Control Board/Authority service area. All information submitted in this application is truthful and any subsequent discovery of misstatement or omission constitutes cause for immediate dismissal from service in the Genesee Medical Control Board/Authority service area.

In making application for operation within the Genesee County Medical Control Board and by completion of this applicant's questionnaire, I acknowledge that this service has received and read the bylaws, rules, regulations, policies, procedures, and protocols of the Genesee County Medical Control system and that this service is familiar with the aforementioned document and agrees to operate in accordance with these documents as they are amended from time to time by the Genesee County Medical Control Board/Authority.

I further understand and agree that the applicant's service has the burden of producing adequate information for proper evaluation of professional performance, competence, character, ethics and qualifications and for resolving any doubts about such qualifications and specifications.

Date

President and/or Chief Executive Officer