

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF OSTEOPATHIC MEDICINE

RENEWAL APPLICATION – PHYSICIAN AND SURGEON (DO)

Full Name

RETURN TO:

Street Address

**State Board of Osteopathic Medicine
PO Box 8417
Harrisburg, PA 17105-8417**

City

State

Zip Code

Email Address

License Number

Check if appropriate

- ADDRESS CHANGE** – The address above is a new address and not on file with the Board.
- NAME CHANGE** – The name above is not the current name on the licensure records. **You must submit a photocopy of a legal document verifying name change (i.e., marriage certificate, divorce decree or legal document indicating retaking of a maiden name, etc.)**
- I will not be practicing this profession in Pennsylvania after the expiration date indicated below and request inactive status. **No fee is required. Form must still be completed – questions answered, signed and dated.**
- I will be retiring from practice but desire to place my license on active-retired status which will allow me to treat immediate family members. I am exempt from the CME requirements, **except for completion of the 2 hours of Board-approved continuing education in child abuse recognition and reporting. Renewal must be completed and fee required.**

SECTION A – THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	<i>If you answer yes to questions 2 through 12, provide details AND attach copies of legal document(s). IF YOU ALREADY REPORTED THE INFORMATION TO THE BOARD PRIOR TO THIS RENEWAL, YOU DO NOT NEED TO REPORT IT AGAIN.</i>
		1. Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession or occupation in any state or jurisdiction? If you answered yes, please provide the profession and state or jurisdiction. LIST: _____
		2. Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?
		3. Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?
		4. Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?
		5. Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.
		6. Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?
		7. Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?
		8. Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?
		9. Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?
		10. Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?

YES	NO	<i>If you answer yes to questions 2 through 12, provide details AND attach copies of legal document(s). IF YOU ALREADY REPORTED THE INFORMATION TO THE BOARD PRIOR TO THIS RENEWAL, YOU DO NOT NEED TO REPORT IT AGAIN.</i>
		11. Since your initial application or last renewal, whichever is later, have you engaged in the imtemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?
		12. Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit? If yes, please submit a copy of the entire Civil Complaint, which must include the <u>filing date</u> and <u>the date you were served</u>. **If you previously reported the complaint to the Board provide the docket number _____
		13. Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania? If you answer "No" please provide an explanation or reason for an exemption request.
		14. Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?
		15. Have you met your continuing education requirements? Please review the continuing education requirements posted on the Board's website at www.dos.pa.gov/ost. Click on General Board Information. If you qualify for an exemption of the continuing education requirements, answer yes to the question. You are required to retain your official continuing education certificates of completion earned for this license renewal period until October 31, 2018.
		16. Please provide the zip code of your primary employer/practice location. This data is being collected for the purpose of identifying healthcare professionals during state emergencies and may be provided to the Pennsylvania Emergency Management Agency for official use only. Zip Code: _____

SPECIAL NOTICE TO ALL HEALTH-RELATED LICENSEES AND FUNERAL DIRECTORS

ACT 31 OF 2014 – INITIAL TRAINING AND CONTINUING EDUCATION IN CHILD ABUSE RECOGNITION AND REPORTING REQUIREMENTS

The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services (DHS), is providing notice to all health-related licensees and funeral directors that are considered "mandatory reporters" under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure.

Additionally, EFFECTIVE WITH THE FIRST LICENSE RENEWAL AFTER JANUARY 1, 2015, all health-related licensees and funeral directors applying for the renewal of a license issued by the Board shall be required to complete at least 2 hours of Board-approved continuing education in child abuse recognition and reporting requirements as a condition of renewal.

Please note that Act 31 applies to all health-related licensees, regardless of whether they are subject to the continuing education requirements of the applicable board.

Approved providers can be found by clicking on the Act 31 Mandated Child Abuse Reporter Training link on the Department's website at www.dos.pa.gov. Act 31 may be reviewed at the following link: <http://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=2014&sessInd=0&smthLwInd=0&act=31>.

SECTION B – VERIFICATION OF INFORMATION

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

Signature of Licensee (**Mandatory**): _____ Date: _____

EXPIRATION DATE: →	October 31, 2016
FEE – Payable to "COMMONWEALTH OF PENNSYLVANIA" →	\$220.00
Write your license number on your payment. A \$20.00 fee will be assessed for returned payments.	
LATE FEE – \$5.00 per month, or part of a month will be assessed if postmarked AFTER 10-31-16	
PRACTICING ON AN EXPIRED LICENSE MAY RESULT IN DISCIPLINARY ACTIONS AND ADDITIONAL MONETARY PENALTIES	
TO ENSURE YOU RECEIVE YOUR NEW LICENSE BEFORE IT EXPIRES	
RETURN BY: OCTOBER 1, 2016	

- * Required to avoid duplication
- * Anonymous and aggregate reporting only



**Commonwealth of Pennsylvania
Department of Health
2016 Survey of Physicians**

IF YOU HAVE ALREADY SUBMITTED YOUR RENEWAL SURVEY ONLINE, DO NOT MAIL THIS SURVEY.

The Department of Health, with the support of the Department of State, requests that you complete this survey to assist in understanding and describing the physician workforce. Strict controls are placed upon information when shared for the production of statistical reports and analysis. This information, when released to the public, will be in aggregate form only. To view past physician workforce reports, visit www.health.state.pa.us/workforce. Thank you for your cooperation!

1. Year of birth
2. Sex Male Female
3. Hispanic or Latino origin Yes No
4. Race (Check one) American Indian/Alaska Native Asian Black/African-American
 Native Hawaiian/Other Pacific Islander White/Caucasian Two or more races
 Other _____
5. State of residence (State abbreviation) Non-U.S. (check)
- 5a. County of Residence (Codes on page 4) If you do not practice in Pennsylvania, select 00 for county not in Pennsylvania.
6. In which state did you obtain your DO or MD degree? (State Abbreviation) Non-U.S. (check)
- 6a. In what year did you obtain this degree?
7. In which state did you complete your medical internship/residency for your primary specialty?
 (State abbreviation) Non-U.S. (check)
8. In which state were you first licensed as a physician? (State abbreviation) Non-U.S. License (check)
- 8a. In what year was this first license issued?
9. Are you currently in a graduate training program? Yes No
10. Enter the code number that best describes your primary specialty area:

Note: All surgical specialties are listed alphabetically under surgery.

- | | | |
|--|--|---------------------------------------|
| 01= Addiction Medicine | 20= Medical Genetics | 38= Psychiatry – adult |
| 02= Adolescent Medicine | 21= Neonatal-Perinatal Medicine | 39= Psychiatry – child and adolescent |
| 03= Allergy and Immunology | 22= Nephrology | 40= Psychiatry – forensic |
| 04= Anesthesiology | 23= Neurology | 41= Pulmonary Disease |
| 05= Cardiovascular Disease | 24= Neuromusculoskeletal Medicine | 42= Radiation Oncology |
| 06= Critical Care Medicine | 25= Nuclear Medicine | 43= Radiology |
| 07= Dermatology | 26= Obstetrics and Gynecology | 44= Rheumatology |
| 08= Emergency Medicine | 27= Occupational Medicine | 45= Sleep Medicine |
| 09= Endocrinology, Diabetes and Metabolism | 28= Oncology | 46= Surgery – general |
| 10= Family Medicine/General Practice | 29= Ophthalmology | 47= Surgery – colon and rectal |
| 11= Gastroenterology | 30= Otolaryngology | 48= Surgery – neurological |
| 12= Geriatric Medicine | 31= Pathology | 49= Surgery – orthopedic |
| 13= Gynecology only | 32= Pediatrics – general | 50= Surgery – pediatric |
| 14= Hematology | 33= Pediatrics – subspecialties | 51= Surgery – plastic |
| 15= Hospice and Palliative Medicine | 34= Pharmacology | 52= Surgery – thoracic and cardiac |
| 16= Hospitalist | 35= Physical Medicine and Rehabilitation | 53= Surgery – vascular |
| 17= Infectious Diseases | 36= Preventive Medicine | 54= Surgery – other |
| 18= Internal Medicine – general | 37= Psychiatry – general | 55= Urology |
| 19= Maternal and Fetal Medicine | | 56= N/A |

- 10a. Did you complete an accredited residency program or fellowship in your primary specialty? Yes No N/A



- 10b. Are you ABMS or AOA certified in your primary specialty? Yes No N/A
- 10c. Are you actively engaged in maintenance of certification? Yes No N/A
- 10d. Are you actively practicing your primary specialty? Yes No >> if 'No,' skip to question 11.
- 10e. In which state are you primarily practicing your primary specialty? (State abbreviation) Non-U.S. (check)
- 10f. In which county are you primarily practicing your primary specialty? (Codes on page 4)
If you do not practice in Pennsylvania, select 00 for not in Pennsylvania.
- List any other counties in which you practice your primary specialty. (Codes on page 4) 10g. 10h.
11. Do you have a secondary specialty? Yes No >> if 'No,' skip to question 12.
- 11a. Enter the code number from the list in question 10 that best describes your secondary specialty:
- 11b. Did you complete an accredited residency program or fellowship in your secondary specialty? Yes No
- 11c. Are you ABMS or AOA-certified in your secondary specialty? Yes No
- 11d. Are you actively practicing your secondary specialty? Yes No >> if 'No,' skip to question 12.
- 11e. In which state are you primarily practicing your secondary specialty? (State abbreviation) Non-US (check)
- 11f. In which county are you primarily practicing your secondary specialty? (Codes on page 4)
If you do not practice in Pennsylvania, select 00 for not in Pennsylvania.
- List any other counties in which you practice your secondary specialty. (Codes on page 4) 11g. 11h.
12. In the past 12 months, did you volunteer your services as a physician in Pennsylvania? Yes No
13. In the past 12 months, did you provide direct patient care in a safety net facility in Pennsylvania, including volunteer hours?
Note: for the purposes of this survey, a safety net provider includes the following: free health clinic, Federally Qualified Health Center (FQHC), Federally Qualified Health Center Look-Alike (FQHC-LA) or certified rural health clinic (RHC).
 Yes No
14. Have you ever delivered babies as part of your practice? Yes No >> if 'No,' skip to question 15.
- 14a. Do you currently deliver babies as part of your practice? Yes No
- 14b. In the past 24 months, did you stop delivering babies as part of your practice? Yes No
15. What is your current employment status? (Select the best fitting category)
- | | |
|---|--|
| <input type="checkbox"/> Employed in health care (direct, indirect) | <input type="checkbox"/> Unemployed, not seeking work in health care |
| <input type="checkbox"/> Employed, not in health care | <input type="checkbox"/> Unemployed, seeking work in health care |
| <input type="checkbox"/> Unemployed, disabled | <input type="checkbox"/> Retired |

If employed in health care continue to question 16.

If employed, not in health care, unemployed or retired, you have finished the survey. Thank you!

16. Which organization best describes the employer you work for the most hours each week? (Check one)
- | | | |
|--|---|---|
| <input type="checkbox"/> Consulting/contractual/Locum Tenens | <input type="checkbox"/> Insurance | <input type="checkbox"/> Urgent care center/clinic |
| <input type="checkbox"/> Group practice | <input type="checkbox"/> Pharmaceutical company | <input type="checkbox"/> University/academic center |
| <input type="checkbox"/> Government – federal/state/local | <input type="checkbox"/> Private practice – employee | <input type="checkbox"/> Other – Independent organization |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Private practice – full/part owner | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Health system | <input type="checkbox"/> Public health organization – federal/state/local | <input type="checkbox"/> N/A |
17. Which setting best describes where you work the most hours each week? (Check one)
- | | | |
|---|---|--|
| <input type="checkbox"/> Academic institution | <input type="checkbox"/> Hospital – inpatient | <input type="checkbox"/> Office/clinic – Multi specialty |
| <input type="checkbox"/> Ambulatory surgical facility | <input type="checkbox"/> Hospital – outpatient | <input type="checkbox"/> Public Health – federal/state/local |
| <input type="checkbox"/> Business/industry/insurance | <input type="checkbox"/> Long-term care center | <input type="checkbox"/> Research laboratory |
| <input type="checkbox"/> Correctional facility | <input type="checkbox"/> Nursing home | <input type="checkbox"/> Urgent care/convenient care |
| <input type="checkbox"/> Emergency department | <input type="checkbox"/> Office/clinic – Solo practice | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Home health | <input type="checkbox"/> Office/clinic – Single specialty | |
| <input type="checkbox"/> Hospital – federal/state | <input type="checkbox"/> Office/clinic – Free/no charge | |
18. If you are employed by or own a medical practice, does this practice utilize physician assistants as part of the care team?
 Yes No N/A
19. If you are employed by or own a medical practice, does this practice utilize nurse practitioners as part of the care team?
 Yes No N/A
20. Are you currently providing clinical or direct patient care on a regular basis? Yes No >> if 'Yes,' skip to question 21.
- 20a. How many years has it been since you provided clinical or direct patient care?
 Less than 2 years 2 to less than 5 years 5 to less than 10 years 10+ Years



21. Indicate the number of hours you spent in Pennsylvania during a typical week in the past 12 months on each activity below:
 Note: For purposes of this survey, direct patient care includes the amount of time a physician spends directly with patients in a medical setting; including time spent on patient record keeping and patient specific office work. This would also include 'on call' hours if the physician is required to remain in a medical facility.

- 21a. Administration 21b. Research
 21c. Teaching/education 21d. Clinical or direct patient care

If you responded with zero hours of 'clinical or direct patient care,' you have finished the survey. Thank you!

22. Do you accept Medicaid patients? Yes No 22a. Are you accepting new Medicaid patients? Yes No
 23. Do you accept Medicare patients? Yes No 23a. Are you accepting new Medicare patients? Yes No

24. In the past 6 months, have you utilized language interpretive services to patients? (Languages other than English)
 Yes No >> **If 'No,' skip to question 25.**

24a. In which languages did you utilize language interpretive service to patients? (Check all that apply)
 Arabic Chinese French German Hindi Italian
 Korean Russian Sign Language Spanish Urdu Other _____

For questions 25-27, please consider your use of health information technology (HIT) to find, send and receive clinical information in your practice in the past 6 months. Exclude the use of HIT for administrative (i.e., billing) functions and for electronic prescribing. Note that for questions 26 and 27, HIT does not include faxing.

25. Do you routinely use HIT to find clinical information about your patients?
 Yes No >> **if 'No,' skip to question 26.**

25a. If yes, which kinds of clinical information do you use HIT to find? (Check all that apply)
 Care gaps per recommended guidelines (i.e., preventive care, immunizations, etc.) Clinical lists (i.e., problems, allergies, clinical notes) Prescription drug history via state monitoring system
 Images Lab results Recent admits/discharges
 Recent office visits

25b. If yes, the ability to electronically find information has:
 Improved my practice Hindered my practice Made no difference in my practice

26. Do you routinely use HIT to send clinical information (such as that included in 25a.)?
 Yes No >> **if 'No,' skip to question 27.**

26a. If yes, who is the typical recipient of clinical information?
 Patient Other clinician Both
 26b. If yes, the ability to electronically send clinical information has:
 Improved my practice Hindered my practice Made no difference in my practice

27. Do you routinely use HIT to receive clinical information (such as that included in 25a.)?
 Yes No >> **if 'No,' skip to question 28.**

27a. If yes, who is the typical sender of clinical information?
 Patient Other clinician Both
 27b. If yes, the ability to electronically receive clinical information has:
 Improved my practice Hindered my practice Made no difference in my practice

28. In the Past 6 months, have you provided care through the use of telehealth technology?
 Yes No >> **if 'No,' skip to question 29.**

28a. If yes, In what capacity was the telehealth service provided? (Check one)
 Provider to patient Provider to patient and provider to provider Other _____
 Provider to provider

28b. If yes and provided to a patient, where is the patient receiving the telehealth service located? (Check all that apply)
 Academic/medical school Hospital Urgent care/convenient care
 Ambulatory surgical facility Long-term care center Other _____
 Correctional facility Nursing home
 Home Office/clinic

29. In the past 12 months, how satisfied were you with your medical career?

- Very satisfied Satisfied Dissatisfied Very dissatisfied



30. Overall, how satisfied are you with your medical career?
 Very satisfied Satisfied Dissatisfied Very dissatisfied

31. What is the greatest source of your professional **satisfaction**? (Check one)

<input type="checkbox"/> Career growth	<input type="checkbox"/> Patient relationships	<input type="checkbox"/> Teaching opportunities
<input type="checkbox"/> Decision making autonomy	<input type="checkbox"/> Staff relationships	<input type="checkbox"/> N/A — completely dissatisfied
<input type="checkbox"/> Financial reasons – salary/income/benefits	<input type="checkbox"/> Patient care	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Intellectual challenge	<input type="checkbox"/> Practice environment	
	<input type="checkbox"/> Religious/philosophical	

32. What is the greatest source of your professional **dissatisfaction**? (Check one)

<input type="checkbox"/> Administrative burden	<input type="checkbox"/> Lack of available leisure time	<input type="checkbox"/> Staff relationships
<input type="checkbox"/> Decision making autonomy	<input type="checkbox"/> Limited time spent with patients	<input type="checkbox"/> N/A — completely satisfied
<input type="checkbox"/> Health information technology	<input type="checkbox"/> Oversight	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Insurance coverage	<input type="checkbox"/> Patient relationships	
<input type="checkbox"/> Financial reasons – salary/income/benefits	<input type="checkbox"/> Practice environment	
	<input type="checkbox"/> Practice restrictions	

33. How long have you practiced medicine in Pennsylvania?

<input type="checkbox"/> Less than 3 years	<input type="checkbox"/> 11 to less than 16 years
<input type="checkbox"/> 3 to less than 6 years	<input type="checkbox"/> 16+ years
<input type="checkbox"/> 6 to less than 11 years	<input type="checkbox"/> N/A

34. How much longer do you anticipate practicing medicine in Pennsylvania?

<input type="checkbox"/> Less than 3 years	<input type="checkbox"/> 11 to less than 16 years
<input type="checkbox"/> 3 to less than 6 years	<input type="checkbox"/> 16+ years
<input type="checkbox"/> 6 to less than 11 years	<input type="checkbox"/> N/A

35. How much longer do you anticipate practicing direct patient care in Pennsylvania?

<input type="checkbox"/> Less than 3 years	<input type="checkbox"/> 11 to less than 16 years
<input type="checkbox"/> 3 to less than 6 years	<input type="checkbox"/> 16+ years
<input type="checkbox"/> 6 to less than 11 years	<input type="checkbox"/> N/A

36. If you plan to leave direct patient care in Pennsylvania in less than 6 years, indicate your primary reason below (check one).

<input type="checkbox"/> Change careers	<input type="checkbox"/> Financial reasons – salary/income/benefits	<input type="checkbox"/> Retirement
<input type="checkbox"/> Complete further training	<input type="checkbox"/> Physical demands	<input type="checkbox"/> Relocation
<input type="checkbox"/> Dissatisfaction with career	<input type="checkbox"/> Practice demands	<input type="checkbox"/> Stress/burnout
<input type="checkbox"/> End of fellowship/training	<input type="checkbox"/> Practice restrictions	<input type="checkbox"/> Unknown future
<input type="checkbox"/> Family reasons		<input type="checkbox"/> Other: _____

Thank you!

If you are interested in learning more about emergency disaster response effort volunteer opportunities in Pennsylvania, please access www.serv.pa.gov for more information.

Pennsylvania County Codes						
01=Adams	11=Cambria	21=Cumberland	31=Huntingdon	41=Lycoming	51=Philadelphia	61=Venango
02=Allegheny	12=Cameron	22=Dauphin	32=Indiana	42=McKean	52=Pike	62=Warren
03=Armstrong	13=Carbon	23=Delaware	33=Jefferson	43=Mercer	53=Potter	63=Washington
04=Beaver	14=Centre	24=Elk	34=Juniata	44=Mifflin	54=Schuylkill	64=Wayne
05=Bedford	15=Chester	25=Erie	35=Lackawanna	45=Monroe	55=Snyder	65=Westmoreland
06=Berks	16=Clarion	26=Fayette	36=Lancaster	46=Montgomery	56=Somerset	66=Wyoming
07=Blair	17=Clearfield	27=Forest	37=Lawrence	47=Montour	57=Sullivan	67=York
08=Bradford	18=Clinton	28=Franklin	38=Lebanon	48=Northampton	58=Susquehanna	
09=Bucks	19=Columbia	29=Fulton	39=Lehigh	49=Northumberland	59=Tioga	00=Not in PA
10=Butler	20=Crawford	30=Greene	40=Luzerne	50=Perry	60=Union	