ALASKA PHYSICIANS & SURGEONS, INC.

MEMBERSHIP APPLICATION

Alaska Physicians & Surgeons, Inc. (“APS”) is a non-profit corporation composed of Alaska providers (“Members”), organized for the purpose of the furtherance of quality patient care, conformance with state and federal law and to negotiate health care contracts for its Members’ benefit and to provide an administrative and management structure for its Members. In order for APS to successfully attract managed health care contracts and maintain its reputation as an organization comprised of health care professionals committed to providing the highest quality of care, a potential Member must undergo a determination of whether he or she has the appropriate competence, training, character, and other such qualifications as the Board may determine are necessary for Membership. In order to become a Member of APS, an applicant must meet and maintain the following criteria:

1. A Member must maintain unrestricted, a professional license from the State of Alaska.

2. A Member must be a medical staff member, in good standing, at a hospital licensed by the State of A1aska.

   A Member must carry medical malpractice coverage in such amounts as may be set from time to time by the Board of Directors. The Member’s insurer must supply APS with a certificate of insurance which shall state that such insurance coverage shall not be terminated or reduced without ten (10) days’ prior written notice to APS. As a minimum, each Member shall have professional liability coverage of at least $500,000 per occurrence and $1,000,000 aggregate.

4. A Member must abide by all aspects of the Participating Provider Agreement, the Bylaws, and Rules and Regulations of APS as they may be amended from time to time; cooperate with APS and its Members in the implementation of the corporation’s policies and objectives, pay assessments when due; and adhere to the professional ethics of the State Board of Medicine.

5. A Member shall not make any misrepresentation to patients concerning the policy of APS or plan(s) contracting with APS**,** or any misrepresentation regarding the provision of health care services.

6. All applicants for Membership shall deliver to APS adequate information for a proper evaluation of competence, training, character, and other qualifications as required in the Member Appraisal and Reappraisal Process. Material misrepresentations or omissions in an application shall be grounds for denial or revocation of Membership. An applicant may be required to meet with the Board of Directors or its designee. In addition, an applicant must be approved by the Board in order to become a Member.

7. To the extent a Member participates in any managed care contract APS administers, the Member will be obligated to comply with terms of such contract(s) and accept a reasonable number of patient-enrollees for which the Member will be compensated for services provided at the rates set forth in the appropriate contract.

8. Members shall not discuss with other Members the fee structure, financial terms, or service pricing of any agreements Members enter into or consider entering into, including whether or not a specific Member has accepted or rejected a specific agreement.

9. A Member must comply with the quality guidelines and utilization standards required by participating plans and/or established by APS, and participate in, accept the results of and comply with the requirements of the utilization review committees as required by the Participating Provider Agreement, the Bylaws, and the Rules and Regulations of APS. Failure to do so may result in a termination of Membership.

10. A Member must pay Membership assessments levied from time to time by the Board, when due.

The information supplied in this application will aid APS in determining whether you are qualified for Membership in APS, APS may contact third persons and inspect certain documents and records to verify your professional competence and good moral and ethical character, as well as the accuracy of the information contained in the application. You should understand that Membership in APS is not absolute. Membership may be terminated by APS for reasons set forth in the Bylaws of APS You are encouraged to read both the Bylaws and Rules and Regulations of A.PS (which are available for inspection at APS's office) to become familiar with the rights and responsibilities of a Member before accepting Membership, should it be offered to VOW.

Please type or print legibly. Answer all questions completely and attach additional pages if space is insufficient to answer fully.

1. ____
   Name *(First/Middle/Last)*

2. Are you known by any other names? _________

   If yes, please specify: ____
   (First/Middle/Last)

3. ____
   Place of Birth/Date

4. ____
   Current Home Address *(Street/City/State/Zip)* *(Telephone)*

5. ____
   Current Office Address *(Street/City/State/Zip)* *(Telephone)*

6. ____
   Address(es) of Previous Practices(s) *(Street/City/State/Zip/Telephone)*

   ____

   ____

7. Are you a United States citizen? ________

   If no, please explain: ____

   ____

   ____

8. Professional Licenses

Please list all professional licenses you have acquired and attach copies to this application:

____

State/License/Number *Current?* *Expiration Date*

____

State/License/Number *Current?* *Expiration Date*

____

State/License/Number *Current?* *Expiration Date*

9. Have you ever had a license to practice revoked, suspended, limited or denied, or is such action pending? _________

If yes, please explain and include the location, date, and nature of such action:

____

____

____

10. Board Certifications

Please list all board certifications, if applicable, and attach copies of the certifications to this application:

____

Board *Date Certified* *Date Recertified* *Date Next Exam*

____

Board *Date Certified* *Date Recertified* *Date Next Exam*

____

Board *Date Certified* *Date Recertified* *Date Next Exam*

11. Education

Please list all undergraduate, graduate, and/or professional schools you have attended whether or not you received a degree from that institution:

a. Undergraduate

____

School *Location* *Degree* *Date Graduated/Attended*

____

School *Location* *Degree* *Date Graduated/Attended*

b. Graduate

____

School *Location* *Degree* *Date Graduated/Attended*

____

School *Location* *Degree* *Date Graduated/Attended*

c. Other Education

____

School *Location* *Degree* *Date Graduated/Attended*

____

School *Location* *Degree* *Date Graduated/Attended*

12. Professional Society Memberships

____

Name of Society/Location *Date(s) of Membership*

____

Name of Society/Location *Date(s) of Membership*

____

Name of Society/Location *Date(s) of Membership*

13. Have you ever had your membership in a professional society, revoked, suspended, restricted or denied, or is such action pending? _________

If yes, please explain and include society, date, and nature of such action:

____

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____

14. Beginning with the most recent affiliation, please list all locations where you have held hospital staff privileges (if applicable):

Hospital/Location	*Present Status*	*Date(s) of Affiliation*
Hospital/Location	*Present Status*	*Date(s) of Affiliation*
Hospital/Location	*Present Status*	*Date(s) of Affiliation*

15. Beginning with the most recent policy, please list all professional liability policies held during the past five years, and attach a copy of your current insurance certificate:

Insurer	*Agent*	*Amount of Coverage*	*Date(s) of Policy*
Insurer	*Agent*	*Amount of Coverage*	*Date(s) of Policy*
Insurer	*Agent*	*Amount of Coverage*	*Date(s) of Policy*

16. At any time, has your professional liability insurance been canceled or restricted by the carrier, and/or have you been denied professional liability coverage? ________

    If yes, please explain and include the name of the carrier and agent:

    ____

    ____

    ____

17. As a result of your professional practice, have you ever been, or are you currently involved in:

    a. Malpractice litigation or arbitration proceedings? _______

    b. Settlement/negotiation of a malpractice claim out of court? _______

    If you answered “yes” to either of the above, please explain and include the nature of the claim, names of relevant parties, dates, and final or current disposition:

    ____

    ____

    ____

18. Have there ever been or are there currently pending any lawsuits, arbitration, or other complaint proceedings where it was/has been alleged that you engaged in any form of misconduct either related or unrelated to your professional practice? ______

    If yes, please explain and include the nature of the claim(s), names of relevant parties, dates, and final or current disposition:

    ____

    ____

19. Has you employment by, or privileges with, a clinic or hospital ever been revoked, suspended, limited, not renewed or denied, or is such action pending? _______

If yes, please explain and include the name of the clinic or hospital, date(s), and nature of such action:

____

____

____

20. Have you ever surrendered clinical or hospital staff privileges during investigation proceedings either voluntary or involuntary for alleged unprofessional or incompetent conduct, or in return for such investigation being dropped? _____

If yes, please explain: ____

____

____

____

21. Has your participation in any public or private health insurance program, or other professional contractual or business relationship been terminated, suspended, restricted or sanctioned, or is such action pending? ________

If yes, please explain: ____

____

____

____

22. Have you ever been convicted of any crime, either a felony or misdemeanor?

___________________.

If yes, please explain: ____

____

____

____

23. References

Please list three (3) persons, preferably licensed health care professionals, who can attest you your medical knowledge, abilities, skill, experience, ethical character, and/or any other matter covered in this application:

a. ____

(Name) *(Profession)*

____

(Address) *(Telephone)*

b. ____

(Name) *(Profession)*

____

(Address) *(Telephone)*

c. ____

(Name) *(Profession)*

____

(Address) *(Telephone)*

I, ____________________ hereby apply for Membership in Alaska Physicians & Surgeons, Inc. ("APS"). I have read the Corporation's Bylaws and Rules and Regulations, and understand and agree as follows:

All information I have provided, or may be asked to provide in the future, is true and correct to the best of my knowledge. I understand that a material misrepresentation or omission made in connection with information I have supplied or knowingly omitted herein is grounds for denial or future revocation of Membership in APS.

I may be asked to provide further information to supplement or elaborate upon items addressed in this application and shall do so within a reasonable time after requested. I shall also authorize the custodian of any relevant records or documents to permit inspection and copying of the same by an authorized agent of APS. If necessary, I agree to submit to an oral interview by the designee of APS, responding to any information contained in this application.

I authorize APS, its Directors, Officers, employees and/or agents to: (1) contact and consult with persons listed as references in this application, as well as county and state societies and agencies, and/or any others who may have knowledge in regard to information contained herein and any other information bearing on my professional competence and moral and ethical qualifications; and (2) inspect any records or documents relevant to my professional competence, moral, ethical, and other such qualifications.

I release from any and all liability, APS, its Directors, Officers, employees, agents, and representatives with respect to actions taken in good faith pursuant to the investigation and evaluation of my suitability for Membership in APS. I waive any and all legal claims I may have against APS and/or its Directors, Officers, employees, agents, and representatives, as well as any person requested to furnish statements, information records or documents (including otherwise confidential information) relating to my application, whose actions are performed in good faith, in connection with the investigation and evaluation of my qualifications and background.

I am of sound mind and am physically capable of providing competent, professional health care services through APS, without impairment due to chemical dependency and/or substance abuse.

I understand that acceptance of this application does not in and of itself constitute Membership in APS, and that I will be required to execute a Participating Provider Agreement if Membership is offered to me. During the pendency of this application and at all times relevant thereafter, I shall promptly notify APS of any changes in information contained herein.

_______________________ Date

_______________________________________ Signature

_______________________________________ Address

____

____

(________)______________________________ Telephone number