BAY COUNTY MEDICAL CONTROL AUTHORITY #0.06 – BAY COUNTY PROVIDER APPLICATION/QUESTIONNAIRE

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Please provide the name, title, agency.	nailing address, and telephone number of	the President or CEO of the provider
Name	Title	
Address	City/State/Zip	Telephone
your service. It is understood the		ividual designated to speak on the behalf of has the authority to answer any questions cal Control system.
Name	Title	
Address	City/State/Zip	Telephone
	ls of the person responsible for the Bay Control of	
3. Please list all hospitals and past three years.	hospital phone numbers within the medica	al control areas you have served within the
4. Please provide the names a operations during the past three	nd addresses of three professional reference years.	ces who are familiar with you service's
5. Has any owner, operator, mayears?Yes	nager or employee of the service been cor	nvicted of a felony within the past three

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6. Has this service been denied application or the right to jurisdiction within the past three years?	operate within a medical control board/authority
Yes	No
7. Is the service now or at any time within the past three warning, or disciplinary action from any state licensing a	
Yes	No
8. Has the service received notice of infarction, warning board/authority.	or disciplinary action from any medical control
Yes	No
9. Within the past three years has this service been involboard/authority, patients, hospitals or other medical serv	
Yes	No
and its management, are affiliated.	
11. Has this service ever been denied professional liabili	ty and/or practice insurance?
Yes	No
12. Has this service ever been denied licensure and/or op	perating privileges in Michigan or any other state?
Voc	No

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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?		
Any affirmative answer (yes) to the above que Attach the explanation to this application.	estions requires a written detailed explanation of the circumstances.	
Appli	icant's Acknowledgement	
application for service in the Bay County Medin the application is truthful and any subseque	omissions from this application constitute cause for denial of the dical Control Board/Authority service area. All information submitted ent discovery of misstatement or omission constitutes cause for County Medical Control Board/Authority service area.	
applicant's questionnaire, I acknowledge this procedures, and protocols of the Bay County I	e bay County Medical Control Board and by completion of this service has received and read the bylaws, rules, regulations, policies, Medical Control System and this service is familiar with the ate in accordance with these documents as they are amended from time board/Authority.	
	ant's service has the burden of producing adequate information for e competence, character, ethics and qualifications and for resolving any ations.	
Date	President and/or Chief Executive Officer	