DEPARTMENT OF HUMAN SERVICES
DIVISION OF VOCATIONAL REHABILITATION
DISABILITY DETERMINATION BRANCH

STATEMENT OF QUALIFICATIONS AND EXPRESSION OF INTEREST TO PROVIDE PROFESSIONAL SERVICES

MARK WITH AN "X" THE ASSOCIATED PROFESSIONAL SERVICE AND INCLUDE SERVICE DETAILS:

☐ **CONSULTATIVE EXAMINATION SERVICES: _____**
(e.g., Type of Exams and/or Testing)

☐ **MEDICAL CONSULTANT/PSYCHOLOGICAL CONSULTANT SERVICES: _____**
(e.g., MC, PC, Chief MC, or Chief PC)

APPLICANT FULL LEGAL NAME	
DBA	

TYPE OF BUSINESS ENTITY: ☐ **SOLE PROPRIETORSHIP** ☐ **CORPORATION** ☐ **PARTNERSHIP** ☐ **LIMITED LIABILITY COMPANY** ☐ **OTHER—PLEASE EXPLAIN**	**BIRTH DATE**	
	LAST 4 DIGITS OF SSN (FULL SSN WILL BE REQUESTED SEPARATELY)	
	FEDERAL EMPLOYER NO.	
	STATE TAX ID NO.	

SPECIALTY		**SUB-SPECIALTY**	

FOR PHYSICIANS ONLY **BOARD CERTIFIED:** ☐ **YES** ☐ **NO**	**FOR PHYSICIAN'S ONLY** **BOARD ELIGIBLE:** ☐ **YES** ☐ **NO**

ACTIVE HAWAII MEDICAL/PSYCHOLOGICAL LICENSE: ☐ **YES** ☐ **NO**	**HAWAII LICENSE NO.**	
	DATE LICENSE OBTAINED	

MEDICAL/GRADUATE SCHOOL ATTENDED		**YEAR OF GRADUATION**	

WHAT DAYS AND HOURS WILL YOU BE AVAILABLE TO PROVIDE SERVICES?		
HOW MANY HOURS PER WEEK WILL YOU BE ABLE TO PROVIDE CONSULTATIVE SERVICES?	**MINIMUM**	
	MAXIMUM	
LOCATION OF SERVICES:		
ADDITIONAL INFORMATION FOR DDB'S CONSIDERATION		

If the answer to any of the following questions is a "yes," please give full details on a separate sheet of paper.

1. Has your license to practice medicine/psychology in any jurisdiction ever been limited, suspended, or revoked?

   ☐ Yes ☐ No

2. Have your privileges at any institution ever been suspended, diminished, revoked, or not renewed?

   ☐ Yes ☐ No

3. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical/psychological organization?

   ☐ Yes ☐ No

4. Have judgments or settlements been bade against you in professional liability cases, or are there any pending?

   ☐ Yes ☐ No

5. Would your health status in any way affect your ability to perform consultations?

   ☐ Yes ☐ No

6. Have you ever been excluded or otherwise barred from participation in the Medicare or Medicaid program, or any other Federal or Federally assisted programs?

   ☐ Yes ☐ No

7. Do you have any objections to a credentials check with the Federation of State Medical Boards?

   ☐ Yes ☐ No

8. Do you have any objections to a Statewide Criminal Background check? The search will be limited to conviction data and data relating to cases in which the defendant is acquitted, or charges are dismissed, by reason of physical or mental disease, disorder or defect, under chapter 704, HRS, as maintained by the Hawaii Criminal Justice Data Center and does not include data maintained by the FBI or other states.

   ☐ Yes ☐ No

9. **FOR CONSULTATIVE EXAMINATION SERVICES ONLY:** Do you have any support staff or third parties that will assist you in the Consultative Exam process?

   ☐ Yes ☐ No

   If yes, please submit a copy of their appropriate licensing or certifications.

10. **FOR MEDICAL CONSULTANT/PSYCHOLOGICAL CONSULTANT SERVICES ONLY:** Do you have any objections to passing the Social Security Administration (SSA) suitability process? The contract for Medical Consultant/Psychological Consultant services and access to SSA's systems, data, information, and/or premises are contingent on you passing SSA'S suitability process. You may also be subject to a complete background investigation. SSA Human Resources personnel and/or the Defense Counterintelligence and Security Agency (DCSA), SSA's Investigation Service Provider, may contact you for additional information during the completion of your screening and background investigation.

    ☐ Yes ☐ No

11. **FOR MEDICAL CONSULTANT/PSYCHOLOGICAL CONSULTANT SERVICES ONLY:** Do have any objections to being prohibited from performing work under the contract if you are found unsuitable based on the criteria for suitability outlined in 5 CFR 731.202 (b)?

    ☐ Yes ☐ No

Please provide three references:

1.

Name	Title
Address	Telephone
Relationship	

2.

Name	Title
Address	Telephone
Relationship	

3.

Name	Title
Address	Telephone
Relationship	

Street Address
(Where Exams will be performed)

_____

_____

_____

Mailing/Billing Address
(If different)

_____

_____

_____

The undersigned certifies that the information submitted is true and correct and is authorized to bind the Applicant identified above to this Statement of Qualifications and Expression of Interest.

Signature: _____ Date: _____
Title: _____ Fax: _____
Phone: _____
Email: _____