Appendix A: NY Public Health Law §2995-a

1. The department shall collect the following information and create individual Profiles on licensees subject to the authority of the office of professional medical conduct, in a format that shall be available for dissemination to the public: (a) a statement of any criminal convictions (as defined by section 1.20 of the criminal procedure law) within the most recent ten years, under the laws of New York state or any other jurisdiction, for offenses specified by regulations of the department; (b) a statement of any action (other than an action that remains confidential) taken against the licensee pursuant to section two hundred thirty of this chapter or any similar action taken by any other state or licensing entity, within the most recent ten years; (c) a statement of any current limitation of the licensee to a specified area, type, scope or condition of practice; (d) a statement of any loss or involuntary restriction of hospital privileges or a failure to renew professional privileges at hospitals within the last ten years, for reasons related to the quality of patient care delivered or to be delivered by the physician where procedural due process has been afforded, exhausted, or waived, or the resignation from or removal of medical staff membership or restriction of privileges at a hospital taken in lieu of a pending disciplinary case related to the quality of patient care delivered or to be delivered by the physician (notwithstanding paragraph (a) of subdivision three of section twenty-eight hundred three-e of this chapter, as added by chapter eight hundred sixty-six of the laws of nineteen hundred eighty); (e) (i) a statement indicating the number of medical malpractice court judgments and arbitration awards within the most recent ten years in which a payment is awarded to a complaining party (notwithstanding subsection (f) of section three hundred fifteen of the insurance law); and (ii) a statement indicating all malpractice settlements within the most recent ten years in which payment is awarded to a complaining party (notwithstanding subsection (f) of section three hundred fifteen of the insurance law), (A) if the total number of settlements exceeds two; or (B) if the commissioner determines any such settlement could be relevant to patient decision making concerning health care quality. The statement shall include the following: "Settlement payments will appear in this Profile only if the total number of settlements made within the past ten years exceeds two, or if the commissioner of health determines a settlement to be relevant to patient decision making. Settlement of a claim may occur for a variety of reasons, which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim does not necessarily mean that a medical malpractice has occurred." The commissioner may supplement such statement as may be appropriate. (iii) Judgments, awards and settlements shall be reported in graduated categories indicating the level of significance, date and place of the judgment, award or settlement. Information concerning medical malpractice judgments, awards and settlements shall be put in context by comparing an individual licensee's medical malpractice settlements to the experience of other physicians in New York state within the same board specialty. Pending malpractice claims shall not be disclosed to the public under this section. Nothing herein shall be construed to prevent the board from investigating or disciplining a licensee on the basis of medical malpractice claims that are pending; (f) name of medical schools attended and date of graduations; (g) graduate medical education; (h) current specialty board certification and date of certification; (i) dates admitted to practice in New York state; (j) names of hospitals where the licensee has practice privileges; (k) appointments to medical school faculties and indication as to whether a

licensee has had a responsibility for graduate medical education within the most recent ten years; (l) information regarding publications in peer reviewed medical literature within the most recent ten years; (m) information regarding professional or community service activities or awards; (n) (i) the location of the licensee's primary practice setting identified as such; and (ii) the names of any licensed physicians with whom the licensee shares a group practice, as defined in subdivision five of section two hundred thirty-eight of this chapter; (o) the identification of any translating services that may be available at the licensee's primary practice location; (p) whether the licensee participates in the medicaid or medicare program or any other state or federally financed health insurance program; and (q) health care plans with which the licensee has contracts, employment, or other affiliation. 1-a. Each physician licensed and registered to practice in this state shall within thirty days of the transmittal of an initial Profile survey and upon entering or updating his or her Profile information: (a) register and maintain an account with the department's health provider network and any successor electronic system established to facilitate communications between the department and licensed health care providers; or (b) provide an e-mail address to the department which shall be used by the department to communicate with the physician. Licensees shall provide notice to the department of changed e-mail addresses within thirty days of the change. Licensee e-mail addresses shall be confidential and shall not be published as part of the licensee's Profile. The e-mail addresses may be used for department purposes only. 2. nothing in this section shall limit the department's authority to collect, require reporting of, publish or otherwise disseminate information about licensees. 3. Each physician who is self-insured for professional medical malpractice shall periodically report to the department on forms and in the time and manner required by the commissioner the information specified in paragraph (e) of subdivision one of this section, except that the physician shall report the dollar amount (to the extent of the physician's information and belief) for each judgment, award and settlement and not a level of significance or context. 4. Each physician shall periodically report to the department on forms and in the time and manner required by the commissioner any other information as is required by the department for the development of Profiles under this section which is not otherwise reasonably obtainable. In addition to such periodic reports and providing the same information, each physician shall update his or her Profile information within the six months prior to the expiration date of such physician's registration period, as a condition of registration renewal under article one hundred thirty-one of the education law. Except for optional information provided, physicians shall notify the department of any change in the Profile information within thirty days of such change. 5. The department shall provide each licensee with a copy of his or her Profile prior to dissemination to the public. In the manner and time required by the commissioner, a licensee shall be provided the opportunity to correct factual inaccuracies that appear in the Profile. The physician shall be permitted to file a concise statement concerning information contained in the Profile, which shall be disseminated therewith. 6. A physician may elect to have his or her Profile omit certain information provided pursuant to paragraphs (l), (m), (n) and (q) of subdivision one of this section. In collecting information for such Profiles and disseminating the same, the department shall inform physicians that they may choose not to provide such information required pursuant to paragraphs (l), (m), (n) and (q) of subdivision one of this section. 7. A physician who knowingly provides materially inaccurate information under this section shall be guilty of professional misconduct pursuant to section sixty-five hundred thirty of the education law. 8. The department shall establish a toll-free telephone number through which it shall answer

inquiries about and accept orders for hard copy Physician Profiles established pursuant to this section and accept consumer complaints about suspected professional misconduct. The department may charge a nominal fee for producing and mailing a hard copy Physician Profile. 9. The department shall, in addition to hard copy Physician Profiles, provide for electronic access to and copying of Physician Profiles developed pursuant to this section through the system commonly known as the Internet. The department shall update a physician's online Profile within thirty days of receipt of a completed Physician Profile survey or any change in Profile information.10. The commissioner shall require that: (a) Practitioner organizations that are representative of the target group for profiling, and health care consumer organizations, be provided the opportunity to review and comment on the profiling methodology, including collection methods, analysis, formatting, and methods and means for release and dissemination. (b) Comparisons of practitioner Profiles shall be organized according to practitioner areas of practice. 11. The commissioner shall evaluate the utility and practicability of including in the Profile a comparison of malpractice data by geographic area. However, the implementation of the Profile shall not be delayed pending such evaluation.12. The commissioner shall develop and distribute a notice suitable for posting that informs consumers of the availability of Physician Profiles and the telephone numbers and Internet addresses for accessing them. 13. Further study of Physician Profiles. After the initial dissemination of the data identified in subdivision one of this section, the department shall conduct a further study of Physician Profiles as follows: (a) Data sources. The department shall identify the types of physician data to which the public has access, including all information available from federal, state or local agencies which is useful for making determinations concerning health care quality determinations. The department shall study all physician data reporting requirements and develop recommendations to consolidate data collection and eliminate duplicate and unnecessary reporting requirements, or to supplement existing reporting requirements in order to satisfy the requirements of this section. The department shall study the feasibility of incorporating health plan reporting requirements, without imposing any extra burden on the physician, regarding network participation into this section to ensure this information is available, accurate, up-to-date and accessible to consumers. (b) Supplemental information adjustment and security safeguards. The department shall develop a methodology for application to collected physician data that accounts for factors such as frequency, severity and geographic area which shall be used to provide context to reported data. Any such methodology shall not diminish the information reported pursuant to subdivision one of this section. In developing such methodology, the department may consult with physicians, including representatives of appropriate specialty societies. The department may also consult with organizations representing consumers, other health care providers, and health care plans. Any such methodology shall include adequate and appropriate safeguards to ensure the security, accuracy and integrity of health information created, received, maintained, used or transmitted in connection with the statewide health information system. Such safeguards shall be sufficient to meet any minimum standards set by state and federal laws and regulations. (c) Public review. The department shall provide organizations which are representative of consumers, physicians, including representatives of appropriate specialty societies, other health care providers and health care plans the opportunity to review and comment on its determinations and recommendations. The department shall consider such comments, and may amend its determinations and recommendations to reflect them. (d) Report. The department shall provide a report of its determinations and recommendations under this subdivision to the

governor and legislature, and make such report publicly available, on or before January first, two thousand sixteen. The department shall report annually thereafter to the legislature on the status of the Physician Profiles and any recommendations for additions, consolidations or other changes deemed appropriate. 14. The physician data so disseminated shall be updated at regular intervals to be determined by the department. 15. (a) All physician data disseminated shall include the following statements: "THE DATA COLLECTED BY THE DEPARTMENT IS ACCURATE TO THE BEST OF THE KNOWLEDGE OF THE DEPARTMENT, BASED ON THE INFORMATION SUPPLIED BY THE PHYSICIAN WHO IS THE SUBJECT OF THE DATA. WHILE THE DEPARTMENT UTILIZES A VARIETY OF SOURCES OF INFORMATION IN CHECKING THE ACCURACY OF THE DATA REPORTED, WE CANNOT BE SURE THAT ALL OF THE INFORMATION ON THIS WEBSITE IS RIGHT, COMPLETE, OR UP-TO-DATE, AND CANNOT BE RESPONSIBLE FOR ANY INFORMATION THAT IS WRONG OR HAS BEEN LEFT OUT. CONSUMERS ARE ENCOURAGED TO CONSULT OTHER SOURCES TO VERIFY OR OBTAIN ADDITIONAL INFORMATION ABOUT A PHYSICIAN. PENDING LEGAL ACTIONS DO NOT IN ANY WAY INDICATE PARTIES' GUILT, LIABILITY OR CULPABILITY. CASES MAY BE DISMISSED, WITHDRAWN, OR SETTLED WITHOUT PAYMENTS TO PLAINTIFFS. ANY DISPOSITION TO A CASE MAY BE SUBJECT TO APPEAL." The commissioner shall ensure that the full text of the statements appear on each web page of the Physician Profile in a manner that does not require the user of the site to click on a separate link in order to view the statements. (b) The department shall provide on the Physician Profiles an active link to the website maintained by the unified court system containing information on active and disposed cases in the local and state courts in the state. 16. If, after initial dissemination of the physician data required by this section, the department determines that any such data is not useful for making quality determinations, the department shall recommend to the legislature the necessary statutory changes.

Appendix B: State Education Law Article 131 §6524

To qualify for a license as a physician, an applicant shall fulfill the following requirements:

1. Application: file an application with the department;
2. Education: have received an education, including a degree of doctor of medicine, "M.D.", or doctor of osteopathy, "D.O.", or equivalent degree in accordance with the commissioner's regulations;
3. Experience: have experience satisfactory to the board and in accordance with the commissioner's regulations;
4. Examination: pass an examination satisfactory to the board and in accordance with the commissioner's regulations;
5. Age: be at least twenty-one years of age; however, the commissioner may waive the age requirement for applicants who have attained the age of eighteen and will be in a residency program until the age of twenty-one;
6. Citizenship or immigration status: be a United States citizen or an alien lawfully admitted for permanent residence in the United States; provided, however that the board of regents may grant a three year waiver for an alien physician to practice in an area which has been designated by the department as medically underserved, except that the board of regents may grant an additional extension not to exceed six years to an alien physician to enable him or her to secure citizenship or permanent resident status, provided such status is being actively pursued; and provided further that the board of regents may grant an additional three year waiver, and at its expiration, an extension for a period not to exceed six additional years, for the holder of an H-1b visa, an O-1 visa, or an equivalent or successor visa thereto;
7. Character: be of good moral character as determined by the department; and
8. Fees: pay a fee of two hundred sixty dollars to the department for admission to a department conducted examination and for an initial license, a fee of one hundred seventy-five dollars for each reexamination, a fee of one hundred thirty-five dollars for an initial license for persons not requiring admission to a department conducted examination, a fee of five hundred seventy dollars for any biennial registration period commencing August first, nineteen hundred ninety-six and thereafter. The comptroller is hereby authorized and directed to deposit the fee for each biennial registration period into the special revenue funds-other entitled "professional medical conduct account" for the purpose of offsetting any expenditures made pursuant to section two hundred thirty of the public health law in relation to the operation of the office of professional medical conduct within the department of health, provided that for each biennial registration fee paid by the licensee using a credit card, the amount of the administrative fee incurred by the department in processing such credit card transaction shall be deposited by the comptroller in the office of the professions account established by section ninety-seven-nnn of the state finance law. The amount of the funds expended as a result of such increase shall not be greater than such fees collected over the registration period.
9. For every license or registration issued after the effective date of this subdivision, an additional fee of thirty dollars shall be paid and deposited in the special revenue fund entitled "the professional medical conduct account" for the purpose of offsetting any expenditures made pursuant to subdivision fifteen of section two hundred thirty of the public health law. The amount of such funds expended for such purpose shall not be greater than such additional fees collected over the licensure period or for the duration of such program if less than the licensure period.

10. A physician shall not be required to pay any fee under this section if he or she certifies to the department that for the period of registration or licensure, he or she shall only practice medicine without compensation or the expectation or promise of compensation. The following shall not be considered compensation for the purposes of this subdivision: (a) nominal payment solely to enable the physician to be considered an employee of a health care provider, or (b) providing liability coverage to the physician relating to the services provided.
11. No physician may be re-registered unless he or she, as part of the re-registration application, includes an attestation made under penalty of perjury, in a form prescribed by the commissioner, that he or she has, within the six months prior to submission of the re-registration application, updated his or her Physician Profile in accordance with subdivision four of section twenty-nine hundred ninety-five-a of the public health law.

Appendix C: New York State Physician Profile Survey

Please PRINT LEGIBLY so we can record your information accurately

New York State **Physician** Profile

PHYSICIAN SURVEY

1. Physician

Name and mailing address *(Write a preferred address if necessary. This address is for contact purposes and will not be made available to the public.)*

☐ I request this change and/or addition to the data provided.

INSTRUCTIONS

Complete this survey by filling in blanks as directed. Please type or print using blue or black ink.

If any preprinted information appears incomplete or incorrect, write in your changes or additions. Indicate that you have made changes or additions by putting a check mark in the corresponding blue box, like this one:

☐ I request this change and/or addition to the data provided.

If you have questions:
Call the Physician Help Desk 1-888-338-6998

Mail your completed survey to:
NYS Physician Profile
NYS Department of Health
PO Box 5007
New York, NY 10274-5007

2. Signature

ANY LICENSEE WHO FAILS TO TIMELY REPORT OR WHO KNOWINGLY PROVIDES INACCURATE INFORMATION SHALL BE GUILTY OF PROFESSIONAL MISCONDUCT PURSUANT TO SECTION 6530 OF THE EDUCATION LAW.

After you have completed the survey, please sign it here.

_____ _____
Physician Signature *Date*

Under the penalties of perjury, I declare and affirm that the statements made in this profile, including accompanying documents, are true, complete and correct.

3. Additional Contact Information

(This information is for contact purposes and will not be made available to the public.)

Phone number

Fax number

E-Mail

4. License to Practice Medicine

	Number	Date Conferred
New York		
National Provider ID		

4A. Primary Field of Practice

List the code of your primary field of practice.
(See Fields of Practice Codes insert.)

_____
Code

4B. Secondary Fields of Practice

List the codes of your secondary fields of practice.
(See Fields of Practice Codes insert.)

_____ _____ _____ _____
Code Code Code Code

5. HIV Services *(Optional)*

Do you provide HIV services and/or care for patients on ARV?
☐ **Yes** ☐ **No**

Do you accept referrals of new HIV patients?
☐ **Yes** ☐ **No**

Are you certified by AAHIVM and/or member of HIVMA?
☐ **Yes** ☐ **No**

Please PRINT LEGIBLY so we can record your information accurately

6. Education and Certification

Medical School from which you received degree | **Year degree received**

☐ I request this change and/or addition to the data provided.

6A. Graduate Medical Education *(ACGME, AOA or RCPSC accredited programs only)*

	Training Period		Was this training program completed in full?* (*self-reported)	Specialty
	Start Date	End Date		
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

☐ I request this change and/or addition to the data provided.

6B. Board Certifications *(ABMS, AOA or RCPSC recognized boards only)*

☐ **I do not have any of the above board certifications**

Name of Board	Certification Date	Expiration Date *(if applicable)*

☐ I request this change and/or addition to the data provided.

6C. Subspecialty *(if any)*

	Certification Date	Expiration Date *(if applicable)*

☐ I request this change and/or addition to the data provided.

6D. Professional Membership(s) *(Optional)*

Refer to attached cover letter for the inclusion criteria.
Attach a separate sheet if necessary.

☐ I request this change and/or addition to the data provided.

7. Teaching

A. Have you served as a full-time, part-time or adjunct faculty member of a medical school within the past 10 years?

☐ **Yes** ☐ **No**

If yes, list the institutions and beginning and end dates of your appointments.
If an institution is in New York State, list the Medical School Code (See the Survey Codes insert)

	Institution	Start Date	End Date *(if applicable)*
1.			
2.			
3.			

B. Were you responsible for teaching/supervising residents during the past 10 years? ☐ **Yes** ☐ **No**

8. Hospital Privileges

Do you have hospital admitting privileges?

☐ **Yes** **If yes, please list the codes of the hospitals where you have privileges.** *(For NY Hospital Codes, see the Survey Codes insert. For out of state hospital privileges, please provide this information in Section 20 Physician Concise Statement)*

(code)	(code)	(code)	(code)	(code)	(code)	(code)	(code)	(code)	(code)

☐ **No** **I do not have any hospital privileges.**

9. Participation in State or Federal Health Insurance Programs

Indicate your participation in these programs (including through managed care programs; you may indicate specific health plans in Question 19 of this survey)

	Yes, at all practice locations	Yes, at some locations	No
Medicaid			
Medicare			
Child Health Plus			
Family Health Plus			
Others (Specify Below)			

10. Translation Services

Do you have translation services on site at your primary practice location on a regular basis?

☐ **Yes** ☐ **No** **If yes, for what languages? Please list the Language Codes** *(See Language Codes in the Survey Codes insert.) (Note: If you practice in more than one location, your primary location is where you practice most often regardless of whether it is in private or group practice.)*

(code)	(code)	(code)	(code)	(code)	(code)	(code)	(code)	(code)	(code)

11. Malpractice

Have there been any malpractice award payments made on your behalf during the past 10 years?

☐ **Yes** ☐ **No**

If yes, please provide below the information about your malpractice history per event:

- *the type of award (judgment, settlement or arbitration)*
- *the date payment was awarded or the date claim was closed*
- *the payment amount in settlement of action or claim*
- *zip code or county and state of the location where the event occurred*
- *name of your malpractice insurance carrier: please indicate if you are self-insured*

If we have provided pre-printed malpractice information you may find that we have included in your carrier's name, and phone number as well as the claim #. This information is provided to you as a way for you to ascertain any of the above elements if they are missing.

The detail involving the specific dollar amount of the insurer's payment in settlement of the malpractice action or claim, the claim number, and the name of the carrier will not be made public. If the facts as you see them here are not accurate, please note the correction on this form and contact the insurance carrier at the phone number provided. If the list is incomplete, you must provide the above detail for any missing malpractice event within the past 10 years in the space provided.

NOTE: Please note that if you have medical malpractice payments that have been awarded on your behalf you will receive a separate letter regarding how this medical malpractice history will be disclosed to the public. In that letter if you have two or fewer settlements in the past ten year period you will be given the opportunity to provide any additional factual information, including supporting documentation, that you believe pertinent in the Department's consideration of whether this settlement information is relevant to patient decision making and consequently, included in your profile. ***Do not supply any additional information or documentation related to your medical malpractice case at this time. Please supply the required facts only.***

For each event add information here:

Type: Claim Number: Date:

☐ **I request this change and/or addition to the data provided.**

Amount: $

Facility Name:

County and State Name: Zip Code: Carrier Phone Number:

Insurance Company:

12. Licensee Actions

A. New York Licensee Actions

Any action taken by the New York State Board of Professional Medical Conduct against your license within the past 10 years, except those that remain confidential pursuant to the law, must be available on your profile.

There is no record of any action taken against your license by the New York State Board of Professional Medical Conduct.

12. Licensee Actions, *continued*

B. Out-of-State Licensee Actions

Have any actions been taken against you, except those that remain confidential pursuant to law, as a result of professional misconduct proceedings by any other state or licensing entity within the pat 10 years?

☐ **Yes** ☐ **No**

If yes, list the state or licensing entity, date, action taken, and summary of misconduct. (see example, right.)

***Example For Illustration Purposes Only*:**
Date: 08/08/11
State: California
Action: License suspension for one year
Summary: Self-administering anabolic steroids without proper medical indication.

(Attach a separate sheet if necessary.)

Date:

State:

Action:

Summary:

☐ **I request this change and/or addition to the data provided.**

13. Current Limitations

Are there any current restrictions/limitations against you, except those that remain confidential pursuant to law, as a result of actions taken by the NYS Board of Professional Medical Conduct or any similar actions pursuant to any State, Province or County to a specified are, type, scope or condition of practice?

☐ **Yes** ☐ **No**

If yes, list the state, province or county, and describe the restrictions or limitations (Attach a separate sheet if necessary.)

State:

Description:

14 Hospital Privilege Restrictions

Within the past 10 years, has there been any loss or involuntary restriction of your hospital privileges or removal of your medical staff membership related to the quality of patient care you delivered and where procedural due process has been afforded, exhausted or waived?

☐ **Yes** ☐ **No**

If yes, write a summary of the action taken, the facility name, the state where the action was taken and the date of the loss or restriction.

Action Taken	Facility	State	Date

Have you failed to renew your professional privileges or resigned from medical staff membership in lieu of a pending disciplinary case against you related to the quality of patient care you delivered?

☐ **Yes** ☐ **No**

If yes, write a summary of the action taken, the facility name, and the state where the failure to renew or resignation occurred and the date or dates of failure to renew or resignation.

Action Taken	Facility	State	Date

15 Criminal Convictions

Have you been convicted of a crime (felony or misdemeanor) in any state, province or county within the past 10 years?

☐ **Yes** ☐ **No**

If yes, list the offense and date of conviction.

Offense	Conviction Date

OPTIONAL INFORMATION

Completing the final four sections is optional. These sections provide you the opportunity to present additional information about yourself to the public if you choose to do so.

16. Practice Location *(Optional)*

For each practice location, list practice name, complete address, phone number and accessibility. *(If more than one office, list in order of where you practice most often) (If you choose not to report the complete address, please list your county or borough.)*

List the name of the physicians in your practice group. *(attach a separate sheet of paper if necessary.)*

NOTE: This information could be important to patients in order to identify physicians located in specific locations.

Practice Name:
Address:
County/Borough:
Phone:
Accessible to persons with disabilities: ☐ **Yes** ☐ **No**
Physicians:

Practice Name:
Address:
County/Borough:
Phone:
Accessible to persons with disabilities: ☐ **Yes** ☐ **No**
Physicians:

Practice Name:
Address:
County/Borough:
Phone:
Accessible to persons with disabilities: ☐ **Yes** ☐ **No**
Physicians:

Practice Name:
Address:
County/Borough:
Phone:
Accessible to persons with disabilities: ☐ **Yes** ☐ **No**
Physicians:

17. Publications *(Optional)*

List articles or research papers you have published in peer-reviewed medical literature within the past 10 years. *(Include article name, journal name and year. Attach a separate sheet if necessary.)*

Article (100 character maximum)	**Journal (100 character maximum)**	**Year**

18. Professional and Community Service Activities *(Optional)*

List your professional or community service activities or awards achieved. *(attach a separate sheet if necessary.)*

Organization and Service Description

19. Health Plan Contracts or Other Affiliation *(Optional)*

With what health plans are you contracted or affiliated? *Check plans that apply.*

- ❒ ABC Health Plan, Inc; NY
- ❒ Aetna Health Inc.
- ❒ Affinity Health Plan
- ❒ AmeriChoice of NY, Inc.; NY
- ❒ AmeriHealth Health Plan, Inc.; Elmsford
- ❒ Atlantis Health Plan, Inc.; NY
- ❒ Buffalo Community Health, Inc.; Buffalo
- ❒ Capital District Physicians Health Plan; Albany
- ❒ CarePlus, LLC; NY
- ❒ CenterCare, Inc.; NY
- ❒ Cigna Healthcare of NY, Inc.; NY
- ❒ Community Choice Health Plan of Westchester, Inc.; Yonkers
- ❒ Community Premier Plus, Inc.; NY
- ❒ Elderplan, Inc.; Brooklyn
- ❒ Empire HealthChoice HMO
- ❒ Empire HealthChoice, Inc.; NY
- ❒ Excellus Health Plan, Inc.; Rochester
- ❒ Excellus Health Plan, Inc.; Syracuse
- ❒ Excellus Health Plan, Inc.; Utica
- ❒ Finger Lakes HMO (Excellus)
- ❒ GHI HMO Select, Inc.; Kingston
- ❒ Health Insurance Plan of Greater NY, Inc.; NY
- ❒ HealthFirst PHSP, Inc.; NY
- ❒ HealthNet
- ❒ HEALTHNOW NEW YORK; (Community Blue) Buffalo
- ❒ HEALTHNOW NEW YORK; Albany
- ❒ HealthPlus, Inc.; Brooklyn
- ❒ Horizon HealthCare of NY, Inc.; NY
- ❒ Independent Health Association, Inc.; Buffalo
- ❒ Independent Health Association, Inc.; Tarrytown
- ❒ MagnalHealth; Garden City
- ❒ Managed Health, Inc.; (HealthFirst, A+ Health Plan) NY
- ❒ MDNY Healthcare, Inc.; Melville
- ❒ MetroPlus Health Plan; NY
- ❒ MVP Health Plan; NY
- ❒ Neighborhood Health Providers, LLC; NY
- ❒ NYS Catholic Health Plan; (Fidelis Care NY, Better Health Plan)
- ❒ Oxford Health Plans of NY; NY
- ❒ Rochester Area HMO/Preferred Care; Rochester
- ❒ SCHC Total Care, Inc.; Syracuse
- ❒ St. Barnabas Community health Plan (Partners in Health)
- ❒ Suffolk County Department of Health Services; Hauppauge
- ❒ The NY Hospital Community Health Plan; NY
- ❒ UnitedHealthcare fo NY, Inc.; NY
- ❒ UnitedHealthcare of Upstate NY, Inc.; East Syracuse
- ❒ Univera Halth Care (Excellus)
- ❒ Upstate HMO (Excellus)
- ❒ Vytra Health Plans Long Island, Inc.; Melville
- ❒ Wellcare of NY, Inc.; Newburgh
- ❒ Westchester Prepaid Health Services Plan; Tarrytown
- ❒ Other _____

20. Physician Concise Statement *(Optional)*

If you would like to make a concise statement specific to the information that will be contained in your NYS Physician Profile, please enter it here. Only the statement you would like the public to see should be entered in this space. Please note that if medical malpractice payments have been made on your behalf within the past ten year period you will receive a separate mailing which will give you the opportunity to review and comment on how this information will be displayed to the public. You may want to add or modify your concise statement related to medical malpractice at a later time when you have completed your review.

Use this blank page to write any additional notes

Use this blank page to write any additional notes

Use this blank page to write any additional notes

Appendix D: Stakeholders Consulted in Drafting of Report

Consumers	• American Association of Retired Persons (AARP) • New Yorkers for Patient & Family Empowerment • New York Public Interest Research Group (NYPIRG) • PULSE of New York • New York Statewide Senior Action Council • The Peggy Lillis Foundation • Center for Independence of the Disabled New York • Bronx Independent Living Services • Brooklyn Center for Independence of the Disabled • Health Care for All New York • Disabled In Action of Metropolitan New York • Empire State Consumer Project • Gray Panthers, New York City Network • New Yorkers for Accessible Health Coverage • Individuals
Physicians	• Medical Society of the State of New York (MSSNY) • New York Chapter of the American College of Physicians (ACP)
Health Care Organizations and Payers	• Community Health Care Association of New York State (CHCANYS) • Greater New York Hospital Association (GNYHA) • Healthcare Association of New York State (HANYS) • New York Health Plan Association (HPA)
Major Malpractice Insurers in New York State	• FOJP Service Corporation
Current Physician Profile Vendor	• MAXIMUS
Other State Agencies	• New York State Department of Education

Appendix E: SED Registration Renewal Application Insert

New York State Education Department
Office of the Professions
Division of Professional Licensing Services

PLEASE READ THIS AND THE ENCLOSED REGISTRATION RENEWAL DOCUMENT CAREFULLY

This is important information about the registration of your New York State professional license and **the only notice you will receive about your registration renewal** before your current registration expires**.**

- Online Registration Renewal. We strongly encourage you to renew online - it is easy, efficient and quick and you can pay with a credit or debit card. You will find the PIN to log on the renewal system in the enclosed registration renewal notice. Go to our Web site at www.op.nysed.gov/renewalinfo for additional information and the link to the online renewal system. You may also update your address and request an optional professional photo identification card when renewing.

- Registration Renewal and Continuing Education. Answers to questions you may have about the requirements you must meet to renew your registration can be found on our Web site at www.op.nysed.gov/training/. (Note about paper applications: Although the enclosed application may contain references to attached documents, you will note that none are provided. All information is now available on our Web site.)

  NOTE TO SOCIAL WORKERS (LMSWs AND LCSWs) RENEWING FOR REGISTRATION PERIODS BEGINNING FEBRUARY 1, 2015 – YOU MUST ATTEST TO COMPLETION OF CONTINUING EDUCATION ON YOUR RENEWAL APPLICATION. See more information at www.op.nysed.gov/prof/sw/

- Licensed Professional Photo Identification Card. If you choose not to renew online, once you receive your new Registration Renewal Certificate in the mail, you may request an optional professional photo identification card application by calling the Registration & Fees Unit at 518-474-3817 ext. 410, Monday-Friday from 8:30 a.m. to 4:45 p.m. Information regarding the ID card is available on our Web site at www.op.nysed.gov/photoid.

- **NOTE TO PHYSICIANS ABOUT YOUR PHYSICIAN PROFILE**
  You are required to update your Physician Profile with the New York State Department of Health within the six months prior to the expiration date of your registration period as a condition of registration renewal in compliance with section 2995-a(4) of the Public Health Law. Any questions you may have regarding the physician profile program or this requirement can be answered by calling the New York State Physician Profile Help Desk at 1-888-338-6998 or by visiting their Web site at https://commerce.health.state.ny.us.

- PHYSICIANS, PHYSICIAN ASSISTANTS, DENTISTS, DENTAL HYGIENISTS, REGISTERED NURSES, NURSE PRACTITIONERS AND MIDWIVES
  Professional Workforce Surveys. Please take a moment to complete the workforce survey currently being conducted for your profession at www.op.nysed.gov/chws-surveys.htm.

- Month of Birth Renewal System. If this is the first time you are renewing your license registration, please note that we use a month of birth based reregistration system and this is your transitional period. This means that your renewal is for a period of between two and three* years which will end with the month prior to your month of birth. The registration fee is prorated so that you only pay for the number of months included in your transitional period. After your transitional period, your registration periods will be for the full three (or two) year period. Note that continuing education is also prorated during this transitional period – see the information specific to your profession at www.op.nysed.gov/training/.

  *Exception: physicians and medical physicists have a two-year registration period. Transitional registration periods for physicians and medical physicists are between one and two years.

Appendix F: SED Physician Registration Renewal Document

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

Address change
Complete only if change has occurred

LIC:
NME:
YR:
OFF:
EIN:

Street

City

State/Zip

PROFESSION:
PERIOD:

AMOUNT DUE

Complete and sign reverse side of this application

Cat 21:021412

↑ Detach here ↑ ↑ Detach here ↑

THE STATE EDUCATION DEPARTMENT
Division of Professional Licensing Services Albany, New York 12234-1000 (518) 474-3817
www.op.nysed.gov
OP4INFO@MAIL.NYSED.GOV

This is your application to register your professional license for the period indicated above.
Payment and form(s) should be received at least **30 days** prior to the beginning of the new period.

Instructions (see detailed information below):

1. The address will be deemed to be business unless otherwise noted above. Business addresses are released to the public pursuant to the Freedom of Information Law.
2. Answer **all** questions on the reverse side, sign and date the application. An affirmative answer to any part of Question 2 requires submission of additional documentation. (See convictions and charges section that follows). An incomplete application will delay registration.
3. Make your check or money order payable to: *NEW YORK STATE EDUCATION DEPARTMENT.* Payment must be made in US funds drawn on a US bank. Do *not* send cash. Your cancelled check is your receipt.
4. Detach the renewal document and submit it with your payment using the envelope provided.

Information:

Licensee Data: Be certain that this application is for your license and is for the correct profession. If your address is incorrect above, please make the changes on the face of the above renewal document. **Changes of name and/or address must be reported within 30 days.** If you are an employer and have a Federal Employer Identification Number, this should appear above as an EIN number; if this number is not on file, please add or change the above renewal document. We are required by New York State Tax Law to collect social security numbers and employer identification numbers for tax administration.

Deceased Notification: If you are acting on behalf of a deceased licensee, please write the word DECEASED across the face of the renewal document and enclose a photocopy of the death certificate.

Registration: This is your application to reregister your professional license for the period indicated on the top portion of this form. Registration is required if you intend to practice your profession in NEW YORK STATE during the period indicated. If you will not be practicing in NEW YORK STATE, you may, WITHOUT FEE inactivate your registration by answering **"NO"** to Question 1 on the reverse side of this form. This will not affect your license. If you become inactive, a registration certificate WILL NOT be issued, and future notices will not be sent to you until you REACTIVATE your registration. To do so, you must contact the Department and request a registration application. To be registered, you must send both the completed application form and registration fee.

Fees and Penalties: If you are registering, enclose the amount due, payable by check or money order to the NEW YORK STATE EDUCATION DEPARTMENT, in US funds drawn on a US bank. Do not send cash. A $25 penalty fee will be charged, in addition to the original fee owed, to anyone who submits a bad check for payment of registration fees. Replacement fees must be paid by certified check, bank check, or money order. If replacement fees are not submitted within 60 days of the notice of a bad check, registration will be voided. Licensees who fail to reregister by the expiration of their current registration period and who continue to practice are subject to a $10 per month late registration fee. Willful failure to reregister constitutes professional misconduct. Registration fees are not refundable once the registration period has begun.

(Continued on other side)

1. Do you wish to register for the period indicated? ..... ☐ Yes ☐ No

2. Since your last registration application,

a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? ..... ☐ Yes ☐ No

b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? ☐ Yes ☐ No

c. Are criminal charges pending against you in any court? ..... ☐ Yes ☐ No

d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? ..... ☐ Yes ☐ No

e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? ..... ☐ Yes ☐ No

3. a. Are you under an obligation to pay child support? ..... ☐ Yes ☐ No

b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? ..... ☐ Yes ☐ No

4. Are you a U.S. citizen or a qualified alien as defined below? ..... ☐ Yes ☐ No

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct and, further, I attest that I have updated my physician profile within the six months prior to the expiration date of my registration period as a condition of registration renewal in compliance with section 2995-a(4) of the Public Health Law. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution and** may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature _____ Daytime phone ( ) _____ Date _____

Cat21B:101012 **21**

↑ Detach here ↑ ↑ Detach here ↑

(Information, continued)

Convictions and Charges: Provide a brief explanation of the action and circumstances, list any other states where you hold a current license to practice (include license numbers and effective date of licensure), and submit the appropriate documentation identified below:

- If you have been convicted of a felony or misdemeanor in any jurisdiction (including New York), submit a certified copy of the court records. Minor traffic violations, charges that were dismissed, and acquittals do not come under this category.
- If you have been the subject of professional misconduct charges in any jurisdiction (including New York), enclose a copy of any disciplinary charges and/or decisions for each action.
- If you have been the subject of hospital or institutional actions, provide the institution's name and address, and enclose a copy of any documentation of the action.

Child Support Law: The General Obligations Law requires that every applicant for a professional license, permit, or registration, or any renewal thereof, must file a written statement that, as of the date of the filing, he or she is or is not under an obligation to pay child support. **Individuals who are four months or more in arrears in child support or who have failed to comply with a summons, subpoena or warrant relating to a paternity or child support proceeding may be subject to suspension of their business, professional, drivers and/or recreational licenses and permits.** The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable pursuant to section 175.35 of the Penal Law. You must answer whether or not you are under an obligation to pay child support; if you are under such an obligation and you cannot attest to one of the four requirements listed below, ***the registration of*** your license may only be renewed for a period of six months. If at the end of that period you are still unable to attest to meeting one of the four requirements, your license may be suspended following due process. If you are under an obligation to pay child support, you must be able to attest to one of the following **four requirements:** 1) you are not four or more months in arrears in the payment of child support; 2) you are making payments by income execution or by a court agreed payment or repayment plan or by a plan agreed to by the parties; 3) your child support obligation is the subject of a pending court proceeding; or 4) you are receiving public assistance or supplemental security income.

Citizenship/Immigration Status: The Personal Responsibility and Work Opportunity Act of 1996, HR 3437, limits the issuance of professional licenses, registrations and limited permits to United States Citizens or qualified aliens. Answer **"YES"** to Question 4 above if you are a U.S. citizen or: an alien lawfully admitted for permanent residence in the U.S.; an alien granted asylum under Section 207 or 208 of the Immigration and Nationality Act; an alien paroled into the U.S. under Section 212 (d) (5) of the Immigration and Nationality Act for a period of at least 1 year; an alien whose deportation is being withheld under Section 241 (b) (3) of the Immigration and Nationality Act; an alien granted conditional entry pursuant to Section 203 (a) (7) of the Immigration and Nationality Act as in effect prior to April 1980; or non-immigrant with INS approved VISA.

Infection Control Course Work: Licensees in this profession who are engaged in practice in New York State must comply with the statutory requirement for completion of approved course work in infection control and barrier precautions to prevent the transmission of the human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C (HCV) in health care settings. Compliance is achieved by completion of course work offered by a provider approved by the Department of Health and/or the State Education Department or by obtaining an exemption from the training requirement from the New York State Department of Health. Courses offered to fulfill the mandate of the federal Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen Standard do not fulfill the infection control training requirement. Criteria for exemption include: retirement from professional practice; out-of-state practice; no direct contact with patients or potentially contaminated materials; or no direct supervision of others who do have direct patient contact or contact with potentially contaminated materials. Graduation from a New York State registered licensure qualifying professional education program after September 1993 qualifies for completion of the required course work for a period of four years. Licensees in this profession are required to report compliance with this requirement to credentialling organizations with which they are affiliated (e.g. hospitals, nursing home); non-affiliated professionals must provide documentation to the Department of Health on forms provided by an approved course work training provider. To obtain exemption request forms or a list of approved providers, you may write to the **New York State Department of Health, P.O. Box 2051, Empire State Plaza Station, Albany, NY 12220-0051** or call **(518) 474-0925.**

Physician Profile: ***You are required to update your Physician Profile with the New York State Department of Health within the six months prior to the expiration date of your registration period as a condition of registration renewal in compliance with section 2995-a(4) of the Public Health Law. Any questions you may have regarding the physician profile program or this requirement can be answered by the New York State Physician Profile Help Desk at 1-888-338-6998.***

***

Appendix G: Additional Physician Profile Questions for Health Workforce Planning Purposes

Proposed Additional Physician Profile Questions For Health Workforce Planning Purposes

1. Demographics

Race/Ethnicity *(Mark all that apply)*

☐ African American/Black
☐ American Indian/Alaska Native
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ White
☐ Other race

Hispanic/Latino?

☐ Yes
☐ No

2. Background

Where was your residence when you graduated from high school?

☐ New York
☐ Other state in the U.S.
☐ Canada
☐ Other country

3. Current Work Status in Medicine

Indicate the response that best describes your current work status.

☐ Active in medicine
☐ Temporarily inactive in medicine
☐ Permanently inactive in medicine

4. Current Training Status

Indicate the response that best describes your current training status.

☐ Not in training ☐ Resident ☐ Fellow

5. Current Activities in Medicine

Please indicate the number of hours per week in medicine for which the major activity is:

	Hours/Week						
	None	1-9	10-19	20-29	30-39	40-49	50+
Patient Care	☐	☐	☐	☐	☐	☐	☐
Research	☐	☐	☐	☐	☐	☐	☐
Teaching	☐	☐	☐	☐	☐	☐	☐
Administration	☐	☐	☐	☐	☐	☐	☐

6. Patient Care: Practice Locations (All locations)

Indicate the location of sites where you spend the most time providing direct patient care. For each location, indicate the average number of patient care hours per week (in primary and/or secondary specialty), the type of patient care provided and a description of the location.

FOR EACH PRACTICE LOCATION

Practice Name: _____

Address: _____
Number *Street*

Address: _____
City/Town/Village *State* *Zip Code*

Number of patient care hours per week in primary specialty: _____
Number of patient care hours per week in secondary specialty: _____

7. **Which best describes your patient care at this location (*Mark only one*)**

☐ Ambulatory care – medical services
☐ Ambulatory care - surgical services
☐ Inpatient care
☐ Emergency services (emergency room/department)
☐ Other

8. **This location is a: (*Mark only one*)**

☐ Private medical office
☐ Hospital
☐ Freestanding health center or clinic
☐ Urgent care center
☐ Nursing home or other residential facility
☐ State/local health department
☐ Other_____

9. Future Plans

In the next 12 months, do you plan to:

☐ Retire from patient care?
☐ Significantly reduce patient care hours?
☐ Significantly increase patient care hours?
☐ Move to another location in New York and continue practicing?
☐ Move to another state and continue practicing?
☐ None of the above

Appendix H: Physician Profile Feedback

NEW YORK STATE

Search for a Physician

- About the Physician Profile
- Search Tips
- Dictionary
- Disclaimers
- Contact Us
- Give Us Your Feedback

Leave this site:

- Link to NYS DOH Home Page, or
- Link to NYS DOH Center for Consumer Health Care Information

Give Us Your Feedback

We would appreciate your feedback regarding the clarity and organization of the profiles website, as well as your ability to find the doctor's information on-line. After filling in your responses, please click on the **Submit** button below to complete the questionnaire.

1. Please select the category of web site user that best describes you.

Consumer

2. How did you find out about this web site?

Department of Health web site

3. What county or borough do you live in?

4. What was the reason you accessed this website?

- ☐ To select a physician
- ☐ To review my existing physician's profile information
- ☐ Other

5. Did you find the information useful?

○ Very useful ○ Useful ○ Not useful

6. Did you find the information you were looking to find?

○ Yes ○ No

7. What information were you looking for?

- ☐ Education
- ☐ Board certification
- ☐ Practice Location
- ☐ Medical malpractice history
- ☐ Medical license actions
- ☐ Criminal convictions
- ☐ Other information

8. Did you find the design of the website to be "user friendly"?

○ Very user friendly ○ User friendly ○ Not user friendly

9. Please feel free to include any additional comments. Please include a telephone number or email address if you would like a direct response to your comments or to discuss any aspect of the New York Physician Profile. We thank you for your comments. They are most helpful in assisting us improve the public web site

Submit

Appendix I: Physician Profile Online Survey

NEW YORK STATE | Department of Health

New York State Physician Profile Survey

NYS Physician Profile

Welcome to the New York State Physician Profile survey!

Survey Description

The New York State Physician Profile was created by the New York Patient Health Information and Quality Improvement Act of 2000 (§2995 et seq.) with the aim of making it possible for all New York State citizens to obtain information about physicians online. The Physician Profile is a publically available website providing information about individual New York State licensed physicians. This survey is designed to provide feedback on the usability, usefulness and desired physician level data. Your answers to these questions are anonymous and confidential. This survey should take a few minutes to complete.

Contact Information

If you have any questions about the survey, please email us at OPCHSM.web@health.ny.gov.

We appreciate your input!

* 1. Please select the category that best describes your use for the Physician Profile today.

- ◯ Consumer
- ◯ NYS Licensed Physician
- ◯ Other (please specify)

NEW YORK STATE | Department of Health

New York State Physician Profile Survey

Physicians Survey

* 1. Is the information on your profile accurate?

- ◯ Yes
- ◯ No

If not please tell us what is not accurate:

* 2. Do you recommend this site to your patients for more information on a referral/recommendation?

- ◯ Yes
- ◯ No

3. Do you have any recommendations for the Department to reduce the burden of maintaining your profile?

* 4. Do you think it would be helpful to include health plan participation on your profile?

- ◯ Yes
- ◯ No
- ◯ Not sure

5. Please use the space below to provide any additional comments or suggestions for the NYS Physician Profile.

NEW YORK STATE | Department of Health

New York State Physician Profile Survey

Consumer Survey

1. Is this your first visit to the Physician Profile?

- ◯ Yes
- ◯ No
- ◯ Not sure

2. When searching for a physician, what information is important to you in making a decision?
(Choose all that apply)

- [ ] Health Plans Accepted
- [ ] Languages available at the office
- [ ] Physician's gender
- [ ] Whether they are accepting new patients
- [ ] Specialty
- [ ] Medical School
- [ ] Board Certification
- [ ] Information on medical malpractice
- [ ] Information on license actions
- [ ] Information on criminal convictions
- [ ] Hospital Affiliations
- [ ] Professional Activities
- [ ] Research Activities
- [ ] Reviews
- [ ] Cost
- [ ] Quality
- [ ] Other (please specify)

3. Where do you usually get this information?
(Choose all that apply)

- [ ] NYS Physician Profile
- [ ] Private website such as healthgrades, ZocDoc, etc.
- [ ] Association website such as the American Medical Association's Doctor Finder
- [ ] Your health insurance website
- [ ] Application
- [ ] Other (please specify)

4. How does the Physician Profile compare to similar websites with physician information that you have visited?

5. How successful were you in finding the information you were looking for on the Physician Profile?

- ◯ Not at all successful
- ◯ Partially successful
- ◯ Completely successful

If you were not completely successful please explain:

6. Please rate your experience with the Physician Profile in each of the following areas based on your visit today.
(Lowest Score = 1; Best Score = 5)

	1	2	3	4	5
Ease of navigating site	◯	◯	◯	◯	◯
The quality of content	◯	◯	◯	◯	◯
The amount of content	◯	◯	◯	◯	◯
Overall experience	◯	◯	◯	◯	◯

7. Who would you trust the most to collect and present this information? Rank order from most trusted to least trusted.

- Government
- Commercial entity
- Association

8. How old are you?

- ◯ 15-24
- ◯ 25-44
- ◯ 45-64
- ◯ 65+

9. Are you currently covered with health insurance?

- ◯ Yes
- ◯ No
- ◯ Not sure

10. How many times in the past 12 months have you or your immediate family seen a physician?

11. Please use the space below to provide any additional comments or suggestions for the NYS Physician Profile.

Appendix J: In-person Survey

NYS Physician Profile Consumer Survey

Survey Description

The New York State Physician Profile was created after former Governor George Pataki signed the New York Patient Health Information and Quality Improvement Act of 2000 (§2995 et seq.) with the aim of making it possible for all New York State citizens to obtain information about physicians' online. The Physician profile is a publically available website providing information about individual New York State licensed physicians. This survey is designed to provide feedback on the usability, usefulness and desired physician level data. Your answers to these questions are anonymous and confidential.

Survey Directions

This survey will take approximately 15-20 minutes to complete. Questions 1-7 are general questions and questions 8-17 are specific to the New York State Physician Profile. We encourage you to visit the Physician Profile website at www.nydoctorprofile.com in order to be able to answer these questions.

Confidentiality

Your answers to these questions are anonymous and all survey responses will be kept confidential. The paper surveys will be entered into our overall survey database and will be analyzed at the level of general response, not by individual response. Open text responses may be quoted or reworded to convey meaning, but again will be kept anonymous. You will not be personally identified in any analysis or text.

Thank you for your time

1. Are you currently covered with health insurance?
   - ☐ Yes
   - ☐ No
   - ☐ Not Sure

2. How many times in the last 12 months have you seen a physician?
   - ☐ 0
   - ☐ 1-2
   - ☐ 3-5
   - ☐ More than 5 times

3. How old are you?
   - ☐ 15-24
   - ☐ 25-44
   - ☐ 45-64
   - ☐ 65+

4. When searching for a physician what information is important to you in making a decision? (Select all that apply)
    - ☐ Office location
    - ☐ Languages available at the office
    - ☐ Health plans accepted
    - ☐ Physician's gender
    - ☐ Whether accepting new patients
    - ☐ Specialty
    - ☐ Medical School
    - ☐ Residency Program
    - ☐ Fellowship Program
    - ☐ Board Certification
    - ☐ Information on medical malpractice for a particular physician
    - ☐ Information on NY Licensee Actions for a particular physician
    - ☐ Information on Criminal Convictions for a particular physician
    - ☐ Hospital affiliations
    - ☐ Professional activities of a physician
    - ☐ Research activities of a physician
    - ☐ Reviews
    - ☐ Cost
    - ☐ Quality Information
    - ☐ Other: Please specify _____

5. Where do you get this information?
    - ☐ Websites: Please specify _____
    - ☐ Applications: Please specify _____
    - ☐ Organizations: Please specify _____
    - ☐ Other: Please specify _____
6. Who would you trust the most to collect and present this information?
    - ☐ State Government
    - ☐ Commercial Entity
    - ☐ Associations
    - ☐ Other: _____

7. Are you able to find the information you're looking for?
    - ☐ Yes
    - ☐ No

      If not what's missing: _____

Please visit the Physician Profile at www.nydoctorprofile.com

8. Is this your first visit to the Physician Profile?
    - ☐ Yes
    - ☐ No
    - ☐ Not Sure
9. When looking for physician information how frequently do you use the Physician Profile?
    - ☐ Never
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

10. Please rate our website in each of the following areas based on your visit today.

    Ease of navigating the site _____

    The quality of the content _____

    Ease of accomplishing what you were trying to do _____

    Overall experience _____

    1- Poor
    2- Below Average
    3- Average
    4- Good
    5- Excellent

11. How would you rate the amount of content on our website
    - ☐ Too much
    - ☐ The right amount
    - ☐ Not enough

12. How successful were you in finding the information you were looking for?
    - ☐ Not at all successful
    - ☐ Partially successful
    - ☐ Completely successful
13. If you were not completely successful please explain

14. On a scale from 1-5 where 1 is not at all likely and 5 is very likely, how likely are you to visit our website again?

1	2	3	4	5
Not at all likely				Very likely

15. How does our website compare to similar websites with physician information that you have visited?
    - ☐ The Physician Profile is much better
    - ☐ The Physician Profile is somewhat better
    - ☐ About the same
    - ☐ The Physician profile is somewhat worse
    - ☐ The Physician Profile is much worse

16. How do you feel the profile can be improved?

17. Please use the space below to provide any additional comments about the NYS Physician Profile.

Thank you for participating in our survey, your input will help to provide better and more meaningful use of the Physician Profile site.

Appendix K: Proposed Modifications for Physician Profile Data Elements

Existing Data Items: Change in Primary Data Source

Data Field	Current Primary Source	Recommended Primary Source
Primary Field of Practice	Physician	PNDS
Secondary Field of Practice	Physician	PNDS
Hospital Privileges	Physician	PNDS
Practice Name	Physician	PNDS
Address	Physician	PNDS
County/Borough	Physician	PNDS
Phone	Physician	PNDS
Wheelchair Accessible	Physician	PNDS
Health Plans	Physician	PNDS
Languages Available	Physician	PNDS

Existing Data Items: Change in Mandatory/Optional Status

Data Field	Current Status	Recommended Status
Teaching Responsibilities	Mandatory	Optional
Institution Name	Mandatory	Optional
Start Date	Mandatory	Optional
End Date	Mandatory	Optional
Responsible for Teaching/Supervising Residents	Mandatory	Optional
Practice Name	Optional	Mandatory
Address	Optional	Mandatory
County/Borough	Optional	Mandatory
Phone	Optional	Mandatory
Wheelchair Accessible	Optional	Mandatory
Health Plans	Optional	Mandatory

New Data Items

Data Field	Primary Source	Recommended By	Mandatory/Optional	Public/Nonpublic
Registration End Date	SED	Consumers	Mandatory	Public
Link to Practice/Professional Website	Physician	Consumers	Optional	Public
Office Hours	PNDS	Consumers	Mandatory	Public
Assistive Technology Available	Physician	Consumers	Mandatory	Public
Telehealth provider	Physician	Consumers	Mandatory	Public
Currently Accepting New Patients	Physician	Physicians/Consumers	Mandatory	Public
Gender	SED/PNDS	Workforce/Consumers	Mandatory	Public
Race/Ethnicity	Physician	Workforce	Mandatory	Nonpublic
Practice Locations	PNDS	Workforce	Mandatory	Nonpublic
Patient Care at this Setting	Physician	Workforce	Mandatory	Nonpublic
State of Residence at High School Graduation	Physician	Workforce	Mandatory	Nonpublic
Current Training Status	Physician	Workforce	Mandatory	Nonpublic
Current Work Status	Physician	Workforce	Mandatory	Nonpublic
Hours spent: patient care, research, teaching, administrative	Physician	Workforce	Mandatory	Nonpublic
Type of Office setting	Physician	Workforce	Mandatory	Nonpublic
Clinical hours/week/specialty	Physician	Workforce	Mandatory	Nonpublic
Future Plans	Physician	Workforce	Mandatory	Nonpublic