MAINE MEDICAL ASSOCIATION
MEDICAL PROFESSIONALS HEALTH PROGRAM

Demographics Form

Referral source: [ ] Self [ ] Board [ ] Employer [ ] Other
Due to a complaint or legal action? [ ] Yes [ ] No

Name: _____ Date: _____

Date of birth: _____ Email: _____

Home address: _____

_____

Mailing address (if different): _____

_____

Preferred phone number: _____ [ ] Home [ ] Cell

Secondary phone number: _____ [ ] Home [ ] Cell

Emergency contact (Name, phone number): _____

Relationship:_____

Marital status: [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widow

_____

Professional: Credentials: _____ Practice specialty? _____

Please list all **professional licenses** and their status (active, inactive, surrendered, revoked):

_____

_____

Current/Most recent employer (*circle employment status*) Name, address, & phone number:

_____

Start date:_____ ***End Date****(if applicable)*:_____

Supervisor name:_____

Please list all health care facilities where you have privileges:

_____

_____

Community/volunteer service: _____

_____

Military: [ ] Never [ ] Current [ ] Discharged, honorable [ ] Discharged, dishonorable

Service dates (if applicable): _____

Service related disabilities: _____