

USA Judo Sports Medicine Application

1. Name in Full: _____
(Last) (First) (Middle) (Maiden) (Degree)

Social Security #: _____

2a. Home Address: _____

(City) (State) (Zip Code+4)

2b. Business Address: _____

(City) (State) (Zip Code +4)

3. Home Telephone: () Business Telephone: ()

4. Place of Birth: _____ Date of Birth: _____
(City, State, Country) (Month, Day, Year)

5. U.S. Citizen: Yes () No () Length of Residency: _____ years

6. Please enter information regarding your state license and send a photocopy of your current State License:

<u>State & Country</u>	<u>Date of Licensure</u>	<u>Exam or Recip.</u>	<u>Status of License (Active, Inactive, etc)</u>
_____	_____	_____	_____
_____	_____	_____	_____

7a. Are you Board Certified? () Yes [include a copy of certificate] () No

7b. What specialty: _____

8. Do you have Subspecialty Board Certification or Certificate of added qualifications in Sports Medicine?
() Yes () No

8b. If YES, send copy of certification showing certifying body and date of issue.

9. Hospitals where you currently have privileges (include addresses):

10. Medical Liability Insurance carrier for both United States and International coverage (Mandatory).

Send Copy of Current Carrier's Face Sheet

11. Send copy of current Basic Cardiac Life Support (BCLS) certification (Mandatory).

12. Current USA Judo Registration# _____ (Send copy, Mandatory)

13a. How many years have you been involved with Judo? _____ years Describe your involvement:

13b. Judo rank? _____ Year? _____

14. Please list your Sports Affiliations, experience in treating athletes and dates below:

<u>PROGRAM</u>	<u>TEAMS</u>	<u>DATES</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, YOU ARE REQUIRED TO FURNISH COMPLETE DETAILS, INCLUDING DATE, PLACE, REASON AND DISPOSITION OF THE MATTER.

	<u>Yes</u>	<u>No</u>
15a. Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse?	_____	_____
b. Have you ever been convicted of violations of any national, Federal, State or Local Statute?	_____	_____
c. Have you ever been denied the privilege of taking an examination given by any licensing board or agency, denied a certificate or license, or refused renewal of a certificate or license?	_____	_____
d. Has any licensing board or agency revoked or suspended a certificate or license issued to you or taken any other disciplinary action?	_____	_____
e. Have you ever had your privileges limited, denied or revoked?	_____	_____
f. Have you ever been denied a DEA registration number or been issued a restricted DEA registration?	_____	_____
g. Have you ever been denied membership or in any way sanctioned by any medical or osteopathic association, society or specialty society?	_____	_____
h. Have you ever voluntarily surrendered a medical license, a controlled substances registration, or DEA registration?	_____	_____
i. To your knowledge, are you the subject of an investigation by any licensing board or agency as of the date of this application?	_____	_____

16. EDUCATION

DATE OF GRADUATION

a. Institution granting College Degree:

b. Institution granting Medical Degree:

(send copy of certificate)

c. Institution of Internship / Residency Training

FROM: TO:

(send copy of certificate)

(month & year)

I CERTIFY THAT ALL THE ABOVE ANSWERS ARE TRUE AND CORRECT. I UNDERSTAND THAT FALSIFICATION OF ANSWERS IS GROUNDS FOR DISMISSAL FROM USJI SPORTS MEDICINE SUBCOMMITTEE.

Signature

Date

Please Send Back To:

Robert S Nishime, MD
Japan Town Medical Group
280 Jackson Street
San Jose, CA 95112
(408) 293-5864