PROFESSIONAL REVIEW QUESTIONNAIRE

(Must be completed by each licensed behavioral health practitioner providing Assessments or Assessment Services: Perpetrator of Domestic Violence)

Please answer the following questions by placing a check mark in the appropriate category. If you answer "yes" to any of the questions please provide a detailed explanation on a separate sheet of paper (EXCEPTION: Question #13).

	YES	NO	N/A
1. Has your license to practice your profession in any jurisdiction ever been refused, limited, suspended, revoked or voluntarily relinquished?	○	○	○
2. Has any action(s) ever been taken against you by the Licensing Board of any state?	○	○	○
3. Has your DEA registration to prescribe controlled substances ever been limited, suspended, revoked or voluntarily relinquished?	○	○	○
4. Have your privileges in any hospital ever been suspended, diminished, revoked, or not renewed involuntarily or voluntarily?	○	○	○
5. Have you ever been reprimanded by, or had your membership refused, suspended, or revoked by any professional organization?	○	○	○
6. Have you ever been named as a party in a malpractice action?	○	○	○
7. Have any claims ever been made against you for professional negligence or malpractice?	○	○	○
8. Have you ever been convicted of a crime other than a minor traffic offense?	○	○	○
9. Are you currently using illegal drugs?	○	○	○
10. Do you have any physical, mental, or addictive problems that may interfere with your ability to carry out the duties and responsibilities of your profession?	○	○	○
11. Have you ever been denied professional liability insurance, or has your policy ever been revoked, canceled, or voluntarily relinquished under a threat of cancellation?	○	○	○
12. Have you ever been the subject of investigation by any peer review committee?	○	○	○
13. Are you able to perform all of the services being requested in this application according to accepted standards of professional performance and without posing a direct threat to clients or others?	○	○	○
14. Are you, your partner(s), or any member of your family involved with, employed by, or part of an investigation with the Department of Children and Families (DCF)?	○	○	○

My signature certifies that I have answered all questions accurately, completely and to the best of my ability. I understand that any misrepresentation or false statement can result in my being withdrawn from the DCF list of providers as well as possible recourse through the Connecticut Department of Public Health.

_____ _____

Signature Date

_____ _____

Printed Name Date of Birth