

Integrated Massachusetts Application for rotaters

Name: _____
Please type or print Degrees

MA. License #: _____

Are you currently in the United States on a temporary visa? Yes** No

**Identify type of visa and sponsor: Visa Type: _____ Sponsor: _____

Is visa being extended to cover period of appointment: Yes No

Questions regarding licensure and prescriptive privileges

1.	Have any disciplinary actions** been threatened, initiated or are any pending against you by a state licensure board?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
2.	Has your license to practice in any state ever been denied, limited, suspended or revoked, diminished, not renewed, relinquished (whether voluntarily or involuntarily) or are any proceedings currently pending which may result in any such action?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
3.	Have your privileges to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, not renewed, surrendered (voluntarily or involuntarily) or have you been called before or warned with regard to these privileges by this state or any jurisdiction or federal agency at any time? Is any such action currently pending?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
4.	Have any formal or written complaints been filed against you with any state professional licensing board?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
5.	Do you hold a narcotic registration for any other state?	Yes* <input type="checkbox"/> No <input type="checkbox"/>

Questions regarding healthcare facility employment and/or privileges:

6.	Has your professional employment ever been suspended, diminished, revoked or terminated at any hospital or healthcare facility or are any proceedings which may result in any such action currently pending?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
7.	Has your medical staff appointment/privileges ever been limited, suspended, diminished, revoked, refused/denied, terminated, restricted, not renewed, relinquished (whether voluntarily or involuntarily) at any hospital or healthcare facility or are proceedings currently pending which may result in any such action?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
8.	Have you ever withdrawn (or voluntarily relinquished) your application for appointment, re-appointment or privileges or resigned from the medical staff because disciplinary action** or loss or restriction of clinical privileges was threatened or before a decision about your appointment and/or privileges was rendered by a hospital's or healthcare organization's governing board?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
9.	Have you ever been the subject of disciplinary action** or proceedings at any healthcare facility?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
10.	Have you ever been investigated for scientific misconduct?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
11.	Have you ever been suspended, sanctioned or restricted from participating in any private, federal or state health program (e.g., Medicare or Medicaid or Blue Cross/Blue Shield)?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
12.	Do you have any financial interest (directly or through family or business partners) in any nursing home, laboratory, pharmacy, medical equipment or supply house or other business to which patients from this facility might be referred or recommended?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
13.	Have you had an application for membership as a participating provider rejected by any HMO/PPO or other prepaid health care plan or your contract as a participating provider terminated by any HMP/PPO or other prepaid plan?	Yes* <input type="checkbox"/> No <input type="checkbox"/>

Questions regarding liability insurance coverage and claims:

14.	Has your professional liability insurance coverage ever been terminated by action of an insurance company?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
15.	Have you ever been denied professional liability insurance coverage?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
16.	Has your present professional liability insurance carrier excluded any specific procedures from your coverage?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
17.	Have there been any suits or claims against you alleging malpractice, negligence, failure to diagnose, etc. which have been pending, opened, or closed during the past ten (10) years?	Yes* <input type="checkbox"/> No <input type="checkbox"/>

Please Note: Liability claims, suits or settlements should include: names, addresses, ages of claimants or plaintiffs; nature and substance of claim; date and place at which claim arose; amounts paid, if any; date and manner of disposition, judgment, settlement or otherwise; date and reason for final disposition; if no judgment or settlement, patient's condition at point of your involvement; patient's condition at end of treatment; and the nature and extent of your involvement with the patient.

continued

Miscellaneous Questions

18.	Are you unable to perform the essential functions of the position for which you have applied or of the privileges you have requested, with or without a reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients or staff?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
19.	Are you currently engaged in the illegal use of drugs?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
20.	Have you engaged in the illegal use of drugs within the past ten (10) years?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
21.	Have you ever been convicted in a criminal action? (Do not include a first conviction for simple assault, speeding, minor traffic violations, affray, disturbance of the peace or any conviction of a misdemeanor more than 5 years prior to this application if there has been no criminal conviction of any offense within 5 years of this application.)	Yes* <input type="checkbox"/> No <input type="checkbox"/>
22.	Has your membership in any local, state or national medical society ever been suspended or terminated?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
23.	Have you ever been the subject of an inquiry or disciplinary action** by any governmental or other regulatory agency? Is any such action pending? (Include all documentation relating to all inquiries whether action taken, dismissed or pending. Copy of complaint(s), response(s) to complaint(s) and any/all BORM letters.)	Yes* <input type="checkbox"/> No <input type="checkbox"/>
24.	Have you <u>failed</u> to complete any CME requirements in the state in which you've been practicing?	Yes* <input type="checkbox"/> No <input type="checkbox"/>

* Please use Page #5 if you answered "Yes" to any of these questions.

** Please see Page #7 for definition of "Disciplinary Action"

Applicant's Authorization and Release

I hereby apply for:

1. Medical/professional staff appointment and clinical privileges as requested herein at each hospital to which I submit this application (Hospital); and
2. Participation as a network or health plan provider with each provider network or health plan to which I submit this application (Health Plan).

I am willing to make myself available for interviews in regard to this application. I also agree to provide each Hospital and Health Plan with updated information regarding all questions on this application form as such information becomes available and such additional information as may be requested by the hospital(s), Health Plan(s) or their respective authorized representatives. I understand that failure to provide all information requested will prevent evaluation of and/or action on my application.

I hereby attest that the information in or attached to this application is true and complete and fairly represents the current level of my training, experience, capability and competence to practice the clinical privileges requested. Any misrepresentation, misstatement, or omission from this application, whether intentional or not, may constitute sufficient cause for rejection of this application resulting in denial of Hospital appointment and clinical privileges or Health Plan network participation. In the event that Hospital appointment or privileges, or Health Plan network participation, has/have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in termination of such appointment or privileges, or network participation.

I understand that with the exception of information determined by the Hospital or Health Plan to be peer review protected, I have the right to request in writing and subsequently review any information obtained by the Hospital or Health Plan to support its evaluation of my application and to correct any erroneous information.

I agree that if I am granted Hospital clinical privileges or Health Plan network participation, I will maintain during the term of my appointment or participation malpractice insurance coverage in an amount equal to or greater than the minimum required by the Hospital or Health Plan respectively and with a carrier acceptable to the Hospital or Health Plan respectively.

I hereby authorize the Hospital and the Health Plan to consult with any representative(s) of the medical/professional or administrative staff of any health care organizations with which I have or have had employment, practice, association or privileges, and any other organizations (including without limitation state licensing boards and the National Practitioner Data Bank) or individuals who have information bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications, and to inspect such records which shall be material to the evaluation of my professional qualifications and competence to carry out the privileges I am requesting, as well as to my moral and ethical qualifications.

I hereby authorize any health care organizations with which I have or have had employment, practice, association or privileges, and any other organizations (including without limitation state licensing boards and the National Practitioner Data Bank) or individuals who have information bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualification to provide and/or release information (both written and oral) to representatives of the Hospital and its medical/professional staff and to the Health Plan bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications. Such information includes but is not limited to information regarding any and malpractice actions, pending or final disciplinary actions and alterations in privileges, and any information with respect to whether I am able to perform the essential functions of the position for which I have applied or the privileges I have requested with or without a reasonable accommodation, according to accepted standards of professional practice and without posing a direct threat to patients or staff (including without limitation information regarding any impairment due to the use of drugs or alcohol).

I authorize and request my medical malpractice liability insurance carrier to release information to the Hospital and Health Plan regarding any claims or actions for damages pending or closed, whether or not there has been a final disposition.

If requested, I agree to undergo a mental or physical examination, prior to or during the term of my appointment to determine whether I am able to perform the essential functions of the position for which I have applied or for the privileges which I have requested, with or without a reasonable accommodation, according to accepted standards of professional performance and without posing a threat to patients or staff.

I agree to notify the Hospital and Health Plan as soon as I become aware that any health care organization, Hospital or any licensing, certifying or regulatory authority has initiated or taken disciplinary action of any kind against me, or has initiated an investigation as a result of a complaint or allegation against me.

I hereby release from liability any and all individuals and organizations who, in good faith and without malice, provide information to the Hospital and Health Plan or to their respective medical/professional staff for the purpose of evaluating this application. I also hereby release from liability the Hospital and Health Plan, their respective medical/professional staffs and their respective agents and representatives for their acts performed in good faith and without malice in connection with the evaluation of my professional skills, competence, character, credentials and qualifications and the exchange of information with respect to my professional skills, competence, character, credentials and qualifications.

I agree that a photocopy of this Authorization and Release will be as valid as the original, and that this Authorization and Release will remain valid as to each Hospital and Health Plan unless revoked by me in writing, or the date on which the Hospital or Health Plan next conducts re-credentialing of my status with the Hospital or Health Plan.

Applicant's Authorization and Release (cont'd)

This Section Applies to Applications for Hospital Appointments and Privileges:

I acknowledge that (1) a medical/professional staff appointment and clinical privileges at the Hospital is not a right of every licensed professional who makes application for the same; (2) my request will be evaluated in accordance with prescribed procedures defined in the Hospital(s) and Medical/Professional Staff Bylaws, policies and procedures, and rules and regulations; (3) all recommendations relative to my application are subject to the ultimate action of the Hospital Board, whose decision shall be final; (4) if appointed, my initial appointment and clinical privileges shall be provisional for the time period determined by the Board; (5) I have the responsibility to keep this application current by informing the Hospital of any change in my professional liability insurance coverage, the filing of a lawsuit against me and any change in my medical/professional staff status at any other hospital, or with any other health care organization or professional organization; and (6) reappointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the Hospital, as evidenced by appropriate treatment and continuous care of patients for whom I have responsibility, and acceptable performance of all duties related thereto as well as the other factors deemed relevant by the Hospital. Reappointment and continued clinical privileges shall be granted only on formal application, according to Hospital and Medical/Professional Staff Bylaws, policies and procedures and upon final approval of the Hospital Board.

I have received and had an opportunity to read the Bylaws of the Medical/Professional Staff. I specifically agree to abide by all such bylaws and any policies and procedures that are applicable to appointees to the Medical/Professional Staff.

If appointed or granted clinical privileges, I specifically agree to: (1) refrain from fee splitting or other inducements relating to patient referral; (2) refrain from delegating responsibility for diagnosis or care of hospitalized patients to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised; (3) refrain from deceiving patients as to the identity of any practitioner providing treatment or services; (4) seek consultation whenever necessary or required; (5) abide by generally recognized ethical principles applicable to my profession; (6) abide by standards of clinical practice that may be in effect from time to time; (7) provide continuous care and supervision as needed to all patients in the hospital for whom I have responsibility; and (8) as required by my appointment to the Hospital(s), accept committee assignments and such other duties and responsibilities as shall be assigned to me by the Hospital(s) Board and medical/professional staff.

This Section Applies to Applications for Participation in Provider Networks:

I acknowledge that (1) participation in the provider network or networks operated or contracted by the Health Plan is not a right of every licensed professional who makes application for the same; (2) acceptance of this application does not constitute approval or acceptance of participation until such time as a provider contract is executed by me and the Health Plan to which I have applied; (3) my request will be evaluated in accordance with prescribed procedures defined in the Health Plan's policies and procedures; (4) all recommendations relative to my application are subject to the ultimate action of the Health Plan's credentialing committee, or other governing body designated by the Health Plan, whose decision shall be final; (5) I have the responsibility to keep this application current by informing the Health Plan of any change in my professional liability insurance coverage, the filing of a lawsuit against me, and any change in my medical/professional staff status, including but not limited to a disciplinary action, at any hospital, or with any other health care organization or professional organization; (6) my continued participation in the provider network remains contingent upon my continued demonstration of professional competence, continued compliance with the Health Plan's credentialing criteria, compliance with the Health Plan's policies and procedures for re-credentialing, and compliance with my contract with the Health Plan; and (7) my complete name and title, specialty or specialties, hospital affiliations, practice addresses, telephone number, languages spoken and handicap accessibility at my practice locations may be included in a physician directory prepared for enrollees of each Health Plan with whom I sign contract.

Further, I authorize the Health Plan(s) to provide my credentialing status to my affiliated provider organization's leaders and notwithstanding anything to the contrary contained in any agreement, I authorize the Health Plan(s) to release my name, address, telephone number, tax identification number and other identifying information to individuals and entities for legitimate business purposes related to the administration of Health Plan products and services.

SIGNATURE: _____ DATE SIGNED: _____

PRINT NAME: _____

If you have answered "yes" to any of the questions on the Application, please supply the information requested below. Use a separate copy of this form for **each** question and indicate the number of the question to which you are responding.

question # _____

PLEASE PRINT OR TYPE RESPONSES

Provider's Name: _____

Medical License Number: _____

Date of Action/Occurrence: _____

Date Claim/Complaint/Criminal Case was filed: _____

Facility Where Incident Occurred: _____

Status of Claim/Complaint/Criminal Care (open, closed, etc): _____

Duration of Occurrence: _____

Professional Liability Carrier Involved: _____

Amount of Settlement: _____

Method of Resolution: Dismissed Judgment for Plaintiff(s)
 Settled with Prejudice Settled without Prejudice
 Judgment for Defendant(s) Mediation or Arbitration
 Letter of advice, consent agreement, letter of concern, warning letter, PHS agreement, other (please include a copy)

Date of Settlement/Action Taken: _____

Where you the primary defendant or co-defendant? YES NO

Detailed Description:

MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE
Definition of “Disciplinary Action” (243 CMR 3.02)

- (1) An action of any entity, including, but not limited to, a governmental authority, a health care facility, an employer, or a professional medical association (international, national, state or local).
- (2) An action which is:
 - (a) formal or informal, or
 - (b) oral or written (except an oral reprimand or admonition is not a “disciplinary action.”)
- (3) Any of the following actions or their substantial equivalents, whether voluntary or involuntary:
 - (a) Revocation of a right or privilege
 - (b) Suspension of a right or privilege
 - (c) Censure
 - (d) Written reprimand or admonition
 - (e) Restriction of a right or privilege
 - (f) Non-renewal of a right or privilege
 - (g) Fine
 - (h) Required performance of public service
 - (i) A course of education, training, counseling, or monitoring, only if such course arose out of the filing of a complaint or the filing of any other formal charges reflecting upon the licensee’s competence to practice medicine
 - (j) Denial of a right or privilege
 - (k) Resignation
 - (l) Leave of absence
 - (m) Withdrawal of an application
 - (n) Termination or non-renewal of a contract with a license
- (4) Divisions (e), (f) and (j) through (n) above are “disciplinary actions” only if they relate, directly or indirectly, to:
 - (a) the licensee’s competence to practice medicine, or
 - (b) a complaint or allegation regarding any violation of law or regulation (including, but not limited to, the regulations of the Board) or bylaws of a health care facility, medical staff, group practice, or professional medical association, whether or not the complaint or allegation specifically cites violation of a specific law, regulation or by-law.
- (5) If based only upon a failure to complete medical records in a timely fashion and/or failure to perform minor administrative functions, the action adversely affecting the licensee is not a “disciplinary action” for the purposes of mandatory reporting to the Board, provided that the adverse action does not relate directly or indirectly to:
 - (a) the licensee’s competence to practice medicine, or a complaint or allegation regarding any violation of law or a Board regulation, whether or not the complaint or allegation specifically cites violation of a specific law or regulation.

Supplemental Release to Applicants of the Partners Healthcare System:

I agree that in the event I am applying for or have been granted medical/professional staff membership or privileges at more than one institution affiliated with Partners HealthCare System, Inc. ("Partners Institution"), such Partners Institutions, including but not limited to the Hospital(s), may exchange or share with each other during the application process or after I have been granted medical/professional staff membership or privileges, any information they deem necessary and appropriate regarding my professional skills, competence, character, credentials and qualifications. I also authorize any Partners Institution where I am applying for or have been granted medical/professional staff membership or privileges to provide a copy of this application and any supporting materials to any other Partners Institution where I am applying for medical/professional staff membership or privileges. I understand that the Partners Institutions do not consider health information about me that is provided to them in connection with my application for staff membership or privileges to be Protected Health Information under the Health Insurance Portability and Accountability Act or its regulations, and that such information may be shared among Partners Institutions as described herein. I hereby release from liability the Hospital(s), any other Partners Institutions at which I am applying for or have been granted medical/professional staff membership or privileges, their medical/professional staffs and their agents and representatives for their acts performed in good faith and without malice in connection with the evaluation of my professional skills, competence, character, credentials and qualifications and the exchange of information with respect to my professional skills, competence, character, credentials and qualifications. In the event I will be receiving my professional liability/medical malpractice insurance coverage through the Controlled Risk Insurance Company (CRICO), I authorize the Hospital(s) to provide CRICO and its agent, the Risk Management Foundation with a copy of those portions of this application relating to my previous professional liability insurance and claims history.

I understand that as part of the Hospital's contractual obligations with various managed care organizations or insurers, it is required to share certain credentialing information with such organizations. I hereby authorize the Hospital(s) (or any entity acting for or on its behalf) to exchange any information it deems necessary and appropriate regarding my credentials and qualifications with any managed care organization (or any entity acting for or on its behalf) of which I am a participant or applying to be a participant. I hereby release from liability the Hospital(s), its medical/professional staff, any managed care organization with which I participate or applying to be a participant, any entity acting for or on behalf of the Hospital(s) or such managed care organizations and their respective agents, employees and representatives, who in good faith and without malice, provide such information. I also release from liability such managed care organizations and their agents and representatives for their acts performed in good faith and without malice in connection with the evaluation of my qualifications and credentials.

Intellectual Property and Other Related Policies:

I understand that the ownership and disposition of inventions and other intellectual property that I create during the time when I have my Professional Staff appointment shall be determined in accordance with the Intellectual Property Policy of the hospital, a copy of which is [for initial appointments: attached hereto and] available at <http://healthcare.partners.org/OGCpolicies/IPIndex.asp>.

I further understand that, in addition to all other institutional policies, I am subject to, and agree to comply with, the Partners Code of Conduct (available at <http://healthcare.partners.org/OGCpolicies/Code/index.html>), the Consulting Policy for Brigham and Women's Hospital, The Massachusetts General and their Affiliated Institutions (available at <http://healthcare.partners.org/OGCpolicies/Consulting.pdf>), and, if I have a Faculty appointment at Harvard Medical School, the Harvard Medical School Policy on Conflicts of Interest and Commitment (available at <http://www.hms.harvard.edu/integrity/conf.html>).

Confidentiality Agreement for Partners HealthCare System, Inc/Partners Community Healthcare, Inc. :

Partners HealthCare System, its affiliates, and Partners Community HealthCare have a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. Additionally, Partners HealthCare System, its affiliates, and Partners Community HealthCare must assure the confidentiality of its human resources, payroll, fiscal, research, computer systems, and management information. In the course of my employment/assignment at a Partners organization/practice, I may come into the possession of confidential information. In addition, my personal access code ["USER ID(s)" and PASSWORD(s)] used to access computer systems is also an integral aspect of this confidential information.

By signing this document I understand the following:

- 1) I agree not to disclose or discuss any patient, human resources, payroll, fiscal, research and/or management information with others, including friends or family, who do not have a need-to-know.
- 2) I agree not to access any information, or utilize equipment, other than what is required to do my job, even if I don't tell anyone else.
- 3) I agree not to discuss patient, human resources, payroll, fiscal, research or administrative information where others can overhear the conversation, e.g. in hallways, on elevators, in the cafeterias, on the shuttle buses, on public transportation, at restaurants, at social events. It is not acceptable to discuss clinical information in public areas even if a patient's name is not used. This can raise doubts with patients and visitors about our respect for their privacy.
- 4) I agree not to make inquiries for other personnel who do not have proper authority.
- 5) I agree not to willingly inform another person of my computer password or knowingly use another person's computer password instead of my own for any reason.
- 6) I agree not to make any unauthorized transmissions, inquiries, modifications, or purgings of data in the system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring data from Partner's computer systems to unauthorized locations, e.g. home.
- 7) I agree to log off prior to leaving any computer or terminal unattended.

I understand that in order for any "USER ID" and/or PASSWORD to be issued to me, this form must be completed. I further understand that computer access activity is subject to audit.

I have read the above provisions regarding release of information, intellectual property and confidentiality and other policies and acknowledge that I am subject to these provisions and policies. I understand that failure to comply with these provisions and policies may result in corrective action, up to and including termination of employment and/or suspension and loss of privileges.

Signed: _____

Date: _____

Please print Name: _____

Brigham & Women's Hospital

ANNUAL COMPUTER KEY SECURITY STATEMENT

In the case of computer entries in the medical record, authentication is accomplished by the person electronically signing the entry by entering his or her own computer key, a personally assigned and unique identifier. This electronic signature has the same effect as a handwritten signature.

THE INTEGRITY OF THIS SYSTEM OF COMPUTER ENTRY IN MEDICAL RECORDS DEPENDS UPON USERS SCRUPULOUSLY MAINTAINING THE SECURITY OF THE PERSONAL IDENTIFIER.

I agree not to disclose the computer key assigned to me to any other person or permit another person to use it. I certify that Brigham and Women's Hospital may regard my electronic signature in the patient medical record as valid and binding.

CHAMPUS ACKNOWLEDGMENT STATEMENT

Champus payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment, or civil penalty under applicable federal laws.

PROPOSED INITIAL DETERMINATION PERMISSION

I give my permission to the UR Department to have access, prior to my review, to quality of care Proposed Initial Determination Notices delivered to them by MassPRO.

MEDICARE ACKNOWLEDGMENT STATEMENT

NOTICE TO PHYSICIANS:

Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment, or civil penalty under applicable federal laws.

I have read the above statements.

Signed by:

Date

Print Name

5/25/99



BRIGHAM AND WOMEN'S HOSPITAL

BWH Professional Staff Identification Verification

Instructions to the Applicant:

- 1) Please attach a recent 2 x 2 photograph (black & white or color is acceptable). Photo must be of your head and shoulder area only.
- 2) You must sign your name in the presence of a Notary Public.

Attach Photo Here

Photo must be of your head and shoulder areas only.

Notary Seal

Signature of Applicant

Printed Name of Applicant

State of _____

County of _____

On this ____ day of _____, 20____ before me the undersigned Notary Public, personally appeared _____ whose photograph above is a genuine likeness of the maker of the signature above and presented satisfactory evidence of identification which were _____.

Signature of Notary

Commission expiration date

Instructions to the Notary Public:

- 1) Please place your seal partially over the photograph and applicant signature.
- 2) Satisfactory evidence of identification must be a valid US or foreign passport or a US issued government ID: i.e. state driver's license, US Military ID card, USCIS ID("Green Card")