

Renewal - 1.049042

Name	TIMOTHY P SPURRELL MD
Credential	1.049042

Fee Details

Renewal Application Fee	\$565.00
	\$565.00

Address Maintenance**Demographic Information**

2. Please provide your Date of Birth.
02/16/1963

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online. It IS NOT necessary that you mail your hardcopy renewal application to the Department after you have renewed online.

The purpose of the next several questions is to allow the Department of Public Health to collect valuable workforce data that is currently unavailable but critical in identifying and addressing healthcare workforce shortage issues.

Thank you for assisting the Department in this important initiative.

Current Workforce Status

3. What is your current work status in Medicine?
Full Time - (30 hours or more per weeeek)

Workforce Survey

4. In the next 12 months, do you plan to (please mark all that apply):

5. If you are **NOT** working in your licensed profession, please indicate your plans for returning to work in your licensed field.

6. Please provide the number of hours per week that you provide DIRECT PATIENT CARE in your primary professional position.

If you do not provide hours in this category, please indicate 0.
65

7. Please provide the number of hours per week that you work as an ADMINISTRATOR/MANAGER in your primary professional position.

If you do not provide hours in this category, please indicate 0.
5

8. Please provide the number of hours per week that you work as an EDUCATOR/FACULTY in your primary professional position.
If you do not provide hours in this category, please indicate 0.
20

9. Please provide the number of hours per week that you work as a RESEARCHER in your primary professional position. If you do not provide hours in this category, please indicate 0.
1

10. If your primary professional position is in a category other than those above, please provide that category in the box below and indicate the number of hours per week.

If you do not provide hours in this category, please indicate 0.

11. Please indicate the setting of your primary professional employment.

Enter comments if "Other" is selected.

12. Gender

13. Race: Choose all that apply:

14. Ethnicity: Please choose one:

Practice Location

If you are providing direct patient care, please identify the location of the primary site where you spend the most time providing direct patient care.

15. Address 1
166 tollgate rd

16. Address 2

17. City
cranston

18. State
ri

19. Zip Code
02886

Primary Source of Payment

What percent of your patients have the following source of Payment?

20. Medicare
less than 10%

21. Medicaid
less than 10%

22. Self-Pay
less than 10%

23. Private Insurance
76 - 100%

24. Other
None

Attestation

25. Have you been convicted of a felony since your last application?
No

26. Have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority since your last application?

No

By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license.

Important Note

Please note that you will receive your new licensing documents (2 wallet-sized cards and 1 suitable for posting) during the third week of next month. DO NOT submit the hardcopy renewal application with an additional fee.

To continue processing your renewal, please click "Next" below.

On the review screen, click "**Add to Invoice.**"

On the top right of the invoice screen, you will be given the option to "**Pay Invoice**" or "**Print Invoice.**" When you are ready to pay the renewal fee, choose "**Pay Invoice**" to process your credit card payment.

Thank you for processing your renewal online.

Review
