

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Application for renewal of: **Physicians**

1. License Number **D0039946** Dr. David Lee Eisenberg

2.	Individual National Provider Identifier NPI: <input type="text" value="1487706883"/> <input type="checkbox"/> I do not have an NPI
	This is the NPI entered in the field for Rendering NPI on a claim (10 digit number)
	<input checked="" type="checkbox"/> NPI Information

3. **EMAIL ADDRESS:** This is your email address on file. If it has changed, please edit below. If you do not have an email address please indicate by checking the checkbox below.

I do not have an email address

**Address Changes (Non-Public and Public):**

You must submit a Public and Non-Public address. If either address has changed, please correct here. Your address(es) on the online renewal application is current as of July 1, 2010. If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

4a. **Non-Public Address:** This address is for Board use only and is **where your license will be mailed**. However, if no public address is listed, this address will also be made available to the public.

Street

Street (2)

Street (3)

City

State    
If selecting a country other than USA or Canada, please choose "Foreign" as your state

ZipCode

Country

4b. **Public Address:** This address, usually your office, is available to the public and will be posted on the Internet. If you do not designate a public address, your non-public address will be posted on the Internet.

Check if Public Address is the same as your Non-Public address (the address above will be automatically entered below.)

Street

Street (2)

Street (3)

City

State    
If selecting a country other than USA or Canada, please choose "Foreign" as your state

ZipCode

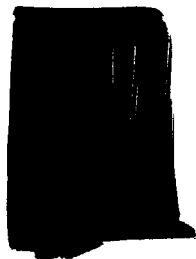
Country

5. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? [See instruction](#)  Yes  No

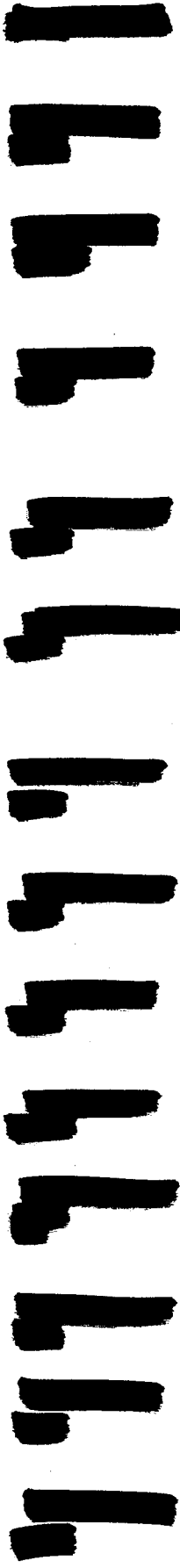
CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2008. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. **If you answer Yes, provide an explanation at the prompt.**

\* All questions must be answered Yes or No.



- a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board)?



or an entity of the armed services?

- c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?
- e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?
- g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?
- h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?
- i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?
- j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?
- k. Do you illegally use drugs?
- l. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?
- m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?
- n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any disciplinary reasons?
- o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?



p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?



q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

CONTINUING MEDICAL EDUCATION (Question 7)

- a. **CME met.** I have earned 50 credit hours of Category 1 continuing medical education during the two (2) years prior to this renewal.
- b. **First Renewal & NPO.** I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for **NEWLY** licensed physicians only. If you were licensed prior to September 30, 2008 or reinstated, this does not apply to you. See New Physician Orientation Program web site. **Your license will not be renewed unless you have completed the orientation.**
- c. **First Renewal after reinstatement.** I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

8. Ethnicity and Race: (Select all that apply)



- Hispanic or Latino
- American Indian or Alaska native
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- White
- Other

9. Are you employed by the Federal Government?

- Yes
- No

10. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical Education or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship (subspecialty) training program accredited by the ACGME.

If you answer Yes to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of this application.

a. In an accredited/approved internship or residency program?

- Yes
- No

b. In an accredited fellowship (subspecialty) training program?

- Yes
- No

11. Which best describes your current area(s) of concentration:

Primary Concentration

Secondary Concentration

12. SPECIALTY BOARD CERTIFICATION: List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Primary Certification

Secondary Certification

13. Please indicate below how the hours in your typical work week are allocated. The sum of these hours should reflect the number of hours in your typical work week. Definitions of these categories are listed below.

If you allocate 0 hours per week to a. Patient Care Related Activities you will not be required to complete the Practice Information section (Questions 15-26) of this application.

**Patient Care Related Activities** include seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic and radiologic assessments), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with other providers about patients, talking with a patient's family members.

**Research** includes clinical, laboratory, and analytical research

**Teaching** includes teaching of medical undergraduate & graduate students and other graduate students.

**Administration & Other:** Administration includes practice management (billing, contract negotiations, personnel, regulatory activities) & management of institutions or programs (health departments, health insurance, hospitals, other health-related institutions or programs); Other

Use whole numbers. No fractional hours. If none enter 0.

a. Patient Care Related Activities	<input type="text" value="40"/>	hours per week
b. Research	<input type="text" value="0"/>	hours per week
c. Teaching	<input type="text" value="0"/>	hours per week
d. Administration & Other	<input type="text" value="0"/>	hours per week
Total Hours	<input type="text" value="40"/>	hours per week

14. If you indicated in Question 13 that you are not engaged in patient care related activities, do you intend to resume patient care related activities in the next 2 years?

Yes  No

PRACTICE INFORMATION (Questions 15-26)

15. Do you plan to discontinue patient care related activities in the next two years?

Yes  No

16. Please indicate below the number of practice/office locations at which you routinely deliver patient care for reimbursement.

a. Number of locations in Maryland (if none, enter 0)

b. Number of locations outside of Maryland (if none, enter 0)

If you have locations outside Maryland, please answer (c) below after you answer (b).

c. Do you routinely treat Maryland patients at your practice/office location(s) outside of Maryland?

Yes  No  Don't know

17. Please indicate below the number of hospitals at which you currently have admitting privileges.

a. Number of hospitals in Maryland (if none, enter 0)

b. Number of hospitals outside of Maryland (if none, enter 0)

**18. Primary Practice / Office Location Primary Practice / Office Location**

Please answer all Primary Practice questions

a. Organization Name

b. Street Address

c. Street2

d. City

e. State

f. Zip Code

g. Jurisdiction

h. Employer Tax ID  [? What is Employer tax ID?](#)  
 Enter "None" if you do not have an Employer tax ID

i. Please select one of the following related to the NPI used for billing insurers:

I use an Organizational NPI for billing. Please Enter >

I use my Individual NPI for billing. Organizational NPI

I do not bill public or private insurers.

j. You indicated in Question 13a, 40 hours of Patient Care Related Activities during a typical work week.  
 How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location?   
 Hours  
 If none, enter 0.

k. Setting

l. Private/Public

m. Practice

Please answer the following regarding staffing at this practice/office location on a typical day.  
 Definition of mid-level medical providers is listed below.  
 If none, enter 0; if you don't know the number, enter 999

Number of physicians (MDs, DOs, residents, fellows) including yourself at this location.

Number of mid-level medical providers at this location.

Mid-level medical providers: nurse practitioners, nurse midwives, nurse anesthetists and physician assistants.

**19. Secondary Practice / Office Location**

No Secondary Location indicated from your response in Question 16.  
 If you have a secondary practice/office location and you've checked the box above, you will see a series of questions that must be completed.

**20. Information Technology (Primary Practice / Office Location)**

Please answer all Primary Practice Information Technology questions

This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients at your primary office/practice location, which you listed in question 18.

Yes  No A. To obtain information about treatment alternatives or recommended guidelines?

B. To send prescriptions electronically to a pharmacy?

Yes  No

If you answered Yes to 20B, what percentage of prescriptions are submitted electronically?  %  Use whole numbers.

Yes  No C. To generate reminders for you about preventive services needed for your patients?

Yes  No D. To access patient notes, medication lists, or problem lists?

Yes  No E. For clinical data and image exchanges WITH OTHER PHYSICIANS?

Yes  No F. For clinical data and image exchanges WITH HOSPITALS AND LABORATORIES?

Yes  No G. To communicate about clinical issues with patients by email?

Yes  No H. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?

21. Does your primary office/practice location use electronic MEDICAL RECORDS (not including billing records)?

Yes, all electronic  Yes, part paper and part electronic  No  Don't know

21a. If No, please indicate your most significant reason for not using electronic medical records.

- Capital cost outlays
- Risk of privacy breaches
- Retiring soon
- Overburdened staff
- Lack of technology standards
- Not my decision
- Physician resistance to adoption
- Intangible benefits

22. Please indicate if you participate in the following private and public insurance programs, and whether you are currently accepting new public insurance program patients.

- a. Participate in any PRIVATE insurance plan networks, including PPO, EPO, HMO, etc.  Yes  No
- b. Participate in the MARYLAND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed Care Organization)  Yes  No
  - b1. If Yes, are you accepting new Maryland Medical Assistance patients?  Yes  No
- c. Participate in the MEDICARE (in either the traditional program or a Medicare Advantage Plan)?  Yes  No
  - c1. If Yes, are you accepting new Medicare patients?  Yes  No

23. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)

Yes  No  NA

24. Please report the typical number of hours per week you personally provide care to patients on a charity basis (do not include bad debt).

0 hours per week.  If none, enter 0

If you are practicing as an adult primary care specialist (internal medicine, family practice, general medicine), answer Q.25. Otherwise skip to Q.26.

25. Do you charge patients an annual fee for participating on your patient panel (sometime called direct, concierge, or retainer-based practice)?

Yes  No

26. Workers Compensation

Workers Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I hereby certify:

- Not Applicable (Do not complete below)
  - I do not practice in Maryland.
  - I do not employ anyone in my practice in Maryland.
  - I employ one or more persons in my Maryland practice and have the following Workers Compensation coverage.
- If you are a Maryland employer you must provide the information requested below.

Insurance Company

Policy Number

Expiration Date


Enter as MM/DD/YYYY Enter as MM/DD/YYYY

PHYSICIANS EMERGENCY CONTACT INFORMATION

27. As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental Hygiene.

\*Required Field

Please provide the phone number that should be used in the event of an actual emergency.

Daytime \*

Nighttime\*



Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents:

- Chemical
- Biological
- Radiological

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at <http://bioterrorism.dhnmh.state.md.us/volunteer.htm>.

*Thank you for your assistance!*

APPLICATION PACKET FOR EXEMPTION FROM LICENSE FEE

28. CERTIFICATION AND AUTHORIZATION OF LICENSE APPLICATION

Please check the first 3 boxes to certify and affirm your renewal application.

<input checked="" type="checkbox"/>	a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.
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b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period; (b) change in any answer that was originally given in this application.

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d. Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 12/1/2010.

29. Please provide your electronic signature (type your name) below:

Name                                    david eisenberg

Today's Date                            9/6/2010

Last four digits of Social Security Number:                    [REDACTED]

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30. Select a Payment Option here to complete your application.

Please note: Credit cards may be used for online payment only. If you or a 3rd party is sending in payment, it must be by check.

Your renewal fee is:

Credit Card     Send Check     3rd Party Check    [REDACTED]

PAYMENT  
**APPLICATION COMPLETION INFORMATION:**  
 Date Application Started            9/5/2010  
 Date Application Submitted        9/6/2010  
 Confirmation Number                [REDACTED]  
 Payment Method                      [REDACTED]  
 Amount Paid                            [REDACTED]  
 Credit Card Approval No.            [REDACTED]