UNITED STATES JUDO, INC.
Application for Sports Medicine Subcommittee
Physicians (M.D. or D.O.) and certified Athletic Trainers (ATC)

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:

State & Country	Date of Licensure	Exam or Recip.	Status of License (Active, Inactive, etc)

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 U.S.J.I. 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:

PROGRAM	TEAMS	DATES

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.

		Yes	No
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