Medical Provider Application for Employment

IDENTIFYING INFORMATION

Last Name First Middle		Social Security Number
Home Address	City/State/Zip	Home Telephone ( )
Office Address	City/State/Zip	Office Telephone ( )
Birthplace	Date of Birth	Office Fax ( )

PRE-MEDICAL EDUCATION

College/University & Address	City/State/Zip Code	Degree	Graduation Date

MEDICAL EDUCATION

Medical School & Address	City/State/Zip Code	Degree	Graduation Date

INTERNSHIP

Type of Internship	Hospital/Institution/Address	City/State/Zip Code	Dates

RESIDENCIES

Type of Residency	Hospital/Institution/Address	City/State/Zip Codes	Dates

FELLOWSHIPS

Type of Fellowship	Hospital/Institution/Address	City/State/Zip Code	Dates

BOARD CERTIFICATION

If you are a board candidate, indicate date scheduled for boards:

Specialty	Board Name	Certification Date	Recertification Date	Exp. Date

LICENSE/REGISTRATION *Attach copies of medical license & DEA registration.*

Medical License Number		Expiration Date
Previous or Current Licenses in Other States		
State	License #	Expiration Date

DEA Registration Number		Expiration Date
Previous or Current DEA Registration in Other States		
State	Registration #	Expiration Date

PROFESSIONAL LIABILITY INSURANCE *Attach copy of insurance certificate.*

Current Carrier Agent	Limits of Coverage	Effective Dates

Have you been bare for any time during the past five years? Yes___ No___
If yes, please attach detailed explanation.

HOSPITAL PRIVILEGES

Hospital/Institution	Address	City/State/Zip	Status

What is your primary admitting facility?

If no admitting privileges, provide name of responsible admitting doctor.

MEDICAL COMPETENCY REFERENCES

List three professional references who are personally acquainted with, and can evaluate, your professional and clinical perfo rmance, judgment and technical skills, not including current associates or relatives.

Name	Address	City/State/Zip

Do you have any current health problems that could affect your ability to practice? If yes, explain.	Yes No

IN THE PAST THREE YEARS:

Question	Answer
1. Have your privileges at a hospital or other health care facility been denied, limited, suspended, non-renewed, or revoked?	Yes No
2. Have you been involved in proceedings brought by a hospital or other health care facility to deny, limit, suspend, non-renew or revoke your privileges?	Yes No
3. Have you been asked to resign from the staff of a hospital or other health care facility?	Yes No
4. Has your license to practice medicine, or your permit to dispense or prescribe drugs been limited, suspended or revoked in any state?	Yes No
5. Have you been placed on probation by any licensing board?	Yes No
6. Have you been notified to respond to or appear before any licensing or regulatory agency on a complaint of any nature, including, but not limited to, unprofessional or unethical conduct?	Yes No
7. Have disciplinary proceedings been instituted against you by a county or state medical society, hospital/facility board or committee, or Board of Medical Examiners?	Yes No
8. Have you been sued for medical malpractice within the last five years? If yes, are there any claims pending?	Yes No
9. Have you been charged with or convicted of a felony or misdemeanor other than traffic violations?	Yes No
10. Have you been treated or hospitalized for any mental or emotional disorders?	Yes No
11. Have you been treated or hospitalized for use of: Alcohol	Yes No
Narcotics	Yes No
Central nervous system stimulants	Yes No
Central nervous system depressants	Yes No
12. Have you appeared before or met with any official or non-official committee or group at a hospital or other health care facility where you have privileges, that has reviewed any problem or potential situation which was of concern to that facility?	Yes No
If you answered "yes" to any of these questions, full written details must accompany the application.	
To the best of my knowledge, the above statements are true and I have not knowingly withheld any information. Signature Date	

I agree to abide by the Principles of Medical Ethics of the American Medical Association, and Name of Clinic, rules and regulations, and policies/procedures that are promulgated from time to time. I agree to participate in quality management activities in accordance with my responsibilities as a member of the Medical Staff.

Applicant's Signature	Date

Please provide two (2) legible copies of the following additional documents:

- Valid and active medical license
- Malpractice certificate
- Driver license
- Social Security card
- Copy of diploma
- Copies of CEU's
- ACLS/BLS cert