Community Health Programs

Date: _____

MEDICAL STAFF EMPLOYEMENT APPLICATION

NAME: _____ **SS#:** _____
(Last) (title) (First) (Middle)

ADDRESS: OFFICE: _____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE)

HOME: _____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE)

MAY WE CONTACT YOU AT YOUR OFFICE? YES NO

PHONE: OFFICE _____ HOME: _____

SPECIALTY: _____

SUB-SPECIALTY: _____

EDUCATION & TRAINING

HIGH SCHOOL: _____
(NAME) (CITY) (STATE) (ZIP CODE)

COLLEGE: _____
(SCHOOL NAME) (YEAR GRADUATED) (DEGREE)

_____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE)

MEDICAL/PROFESSIONAL SCHOOL: _____
(SCHOOL NAME) (YEAR GRADUATED) (DEGREE)

_____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE)

POST GRADUATE EDUCATION OR TRAINING: _____
(SCHOOL NAME) (YEAR GRADUATED) (DEGREE)

_____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE)

INTERNSHIP: _____
(NAME OF PROGRAM/SPECIALTY) (YEAR GRADUATEDATTENDED) (TELEPHONE)

_____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE)

RESIDENCY TRAINING: _____
(NAME OF PROGRAM/SPECIALTY) (YEAR GRADUATED/ATTENDED) (TELEPHONE)

_____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE)

FELLOWSHIP TRAINING: _____
(NAME OF PROGRAM/SPECIALTY) (YEAR GRADUATED/ATTENDED) (TELEPHONE)

_____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE)

PROFESSIONAL REFERENCES: **PLEASE LIST NAMES OF INDIVIDUALS WHO ARE PERSONALLY FAMILIAR WITH YOUR PROFESSIONAL TRAINING DURING THE FOLLOWING:**

MEDICAL PROFESSIONAL SCHOOL: _____
(NAME & TITLE) (TELEPHONE)

_____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE)

INDICATE RELATIONSHIP: _____

INTERNSHIP: _____
(NAME & TITLE) (TELEPHONE)

_____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE)

INDICATE RELATIONSHIP: _____

RESIDENCY/FELLOWSHIP: _____
(NAME & TITLE) (TELEPHONE)

_____ (STREET ADDRESS)
(CITY) (STATE) (ZIP CODE)

INDICATE RELATIONSHIP: _____

EMPLOYMENT OR OTHER PROFESSIONAL REFERENCES: REFER TO INDIVIDUALS WHO KNOW YOU WELL, THROUGH YOUR TRAINING PROGRAMS OR CURRENT PRACTICE.

1. _____
(NAME AND TITLE) (STREET ADDRESS) (CITY) (STATE) (ZIP CODE) (TELEPHONE)

INDICATE RELATIONSHIP: _____

2. _____
(NAME AND TITLE) (STREET ADDRESS) (CITY) (STATE) (ZIP CODE) (TELEPHONE)

INDICATE RELATIONSHIP: _____

3. _____
(NAME AND TITLE) (STREET ADDRESS) (CITY) (STATE) (ZIP CODE) (TELEPHONE)

INDICATE RELATIONSHIP: _____

ARE YOU PERSONALLY ACQUAINTED WITH ANY PRESENT OR FORMER MEMBER OF OUR MEDICAL STAFF? YES _____ NO _____

NAME: _____

WORK HISTORY, POST INTERN AND/OR RESIDING EXPERIENCE: POSITION HELD, INCLUDING MILITARY SERVICE. LIST LAST POSITION FIRST:

1. POSITION: _____ DATE _____ TO _____

ADDRESS: _____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE) (TELEPHONE)

REASON FOR LEAVING: _____

2. POSITION: _____ DATE _____ TO _____

ADDRESS: _____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE) (TELEPHONE)

REASON FOR LEAVING: _____

3. POSITION: _____ DATE _____ TO _____

ADDRESS: _____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE) (TELEPHONE)

REASON FOR LEAVING: _____

IS ALL PREVIOUS WORK EXPERIENCE LISTED? YES NO IF NOT, PLEASE LIST ON A SEPARATE SHEET OF PAPER AND ATTACH

HOSPITAL PRIVILEGES:

1._____
(HOSPITAL) (STREET ADDRESS) (CITY) (STATE) (ZIP CODE) (TELEPHONE)

_____
(TYPE OF PRIVILEGES)

2._____
(HOSPITAL) (STREET ADDRESS) (CITY) (STATE) (ZIP CODE) (TELEPHONE)

_____
(TYPE OF PRIVILEGES)

3._____
(HOSPITAL) (STREET ADDRESS) (CITY) (STATE) (ZIP CODE) (TELEPHONE)

_____
(TYPE OF PRIVILEGES)

CURRENT MALPRACTICE INSURANCE CARRIER:

_____
(NAME OF CARRIER) (TELEPHONE)

_____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE)

LICENSURE AND BOARD CERTIFICATION:

ARE YOU CURRENTLY BOARD CERTIFIED? _____ WHICH BOARDS? _____ DATE CERTIFIED:_____

ARE YOU ELIGIBLE TO TAKE YOUR SPECIALTY BOARDS? _____ YES _____NO WHEN:_____

WHICH EXAM HAVE YOU TAKEN: _____USMLE (PARTS I, II, III)_____NBOME (PARTS I, II, III)
_____ FLEX (I SITTING, 3 DAYS) _____NBME (PARTS I, II, III)
_____ STATE BOARDS (STATE _____ DATE_____)

CURRENT DEA NUMBER: _____

DO YOU HAVE A LICENSE TO PRACTICE MEDICINE OR ARE YOU A LICENSED PROFESSIONAL? YES _____ NO _____

STATE	**LICENSE NUMBER**	**EFFECTIVE DATE**
_____	_____	_____
_____	_____	_____
_____	_____	_____

PARTICIPATION IN PROFESSIONAL ASSOCIATIONS:

1. _____
2. _____

3. _____

PLEASE LIST ANY PROFESSIONAL HONORS, AWARDS, PUBLICANTIONS OR RESEARCH:

_____

_____

_____

1. HAVE YOU EVER BEEN CONVICTED OF A CRIME? _____ YES _____ NO
2. HAVE YOU EVER BEEN THE SUBJECT OF A MALPRACTICE AWARD OR FINDING, OR NAMED IN A MALPRACTICE SUIT? _____ YES _____ NO
3. HAVE YOU EVER BEEN DENIED A LICENSE OR HAD YOUR LICENSE LIMTIED, SUSPENDED OR REVOKED TO PRACTICE IN ANY STATE? _____ YES _____ NO
4. HAVE YOUR HOSPITAL OR CLINIC STAFF PRIVILEGES EVER BEEN LIMITED, SUSPENDED, DENIED, OR REVOKED? _____ YES _____ NO
5. HAVE YOU EVER BEEN INVOLVED IN ANY OTHER ACTIVITY THAT WOULD CREATE DOUBT ABOUT YOUR ABILITY OR RIGHT TO PRACTICE? _____ YES _____ NO
6. HAVE YOU EVER HAD YOUR DRUG ENFOREMENT ADMINISTRATION CERTIFICATE OR PRESCRIBING PRIVILEGES LIMITED, SUSPENDED OR REVOKED BY ANY STATE OR FEDERAL AGENCY? _____ YES _____ NO
7. IS THERE ANY REASON YOU COULD NOT PRACTICE FULL TIME? _____ YES _____ NO
8. IS THERE ANYTHING PREVENTING YOU FROM COMPLYING WITH ANY PROFESSIONAL REQUIREMENT? _____ YES _____ NO
9. HAVE YOU EVER BEEN DISCHARGED OR REQUESTED TO RESIGN FROM ANY EMPLOYMENT? _____ YES _____ NO
10. HAVE YOU EVER BEEN CONVICTED OF MEDICARE OR MEDICAID FRAUD? _____ YES _____ NO
11. SHOULD YOU BE EMPLOYED, DO YOU PLAN TO ENGAGE IN ANY BUSINESS OR OTHER EMPLOYMENT WHILE EMPLOYED AT COMMUNITY HEALTH PROGRAMS? _____ YES _____ NO

*IF YOU ANSWERED YES TO ANY OF THE AOBVE QUESTIONS, PLEASE EXPLAIN FULLY ON A SEPARATE SHEET OF PAPER AND ATTACH.

AUTHORIZATION AND RELEASE:

I REPRESENT THAT THE INFORMATION ON THIS APPLICATION IS TRUE, COMPLETE AND CORRECT AND AUTHORIZE YOU TO INVESTIGATE AND CONFIRM ALL INFORMATION SUPPLIED. I ALSO AUTHORIZE ANY INDIVIDUAL OR ORGANIZATION NAMED ON THIS APPLICATION TO SUPPLY YOU WITH INFORMATION ABOUT ME AND RELEASE THEM FROM ALL LIABILITY FOR DOING SO.

SIGNATURE: _____ DATE: _____

NAME PRINTED: _____

A CURRICULUM VITAE MAY BE ATTACHED TO THIS FORM.