Medical Staff Employment Application

APPLICANT INFORMATION (please print)

Name: First | Last | Middle

Title

Address | Apt. # | City | State | Zip

Telephone Number ( ) - | Email

EMPLOYMENT

Position(s) Applied For | Department or Practice

Current Office

Address | City | State | Zip

Telephone ( ) -

May we contact you at your office? ☐ Yes ☐ No

Specialty

Sub Specialty

EDUCATION

Name of High School | Location

Years Completed | G.P.A

Telephone ( ) -

Diploma obtained? ☐ Yes ☐ No

Name of College Location

Years Completed G.P.A Telephone

( ) -

Diploma obtained? ☐ Yes ☐ No

Name of Medical/Professional School Location

Year Graduated G.P.A Telephone

( ) -

Diploma obtained? ☐ Yes ☐ No

Name of Post Graduate Education/Training Location

Year Graduated G.P.A Telephone

( ) -

Diploma obtained? ☐ Yes ☐ No

Internship Location

Year Attended/Graduated Telephone

( ) -

Residency Training Location

Year Attended/Graduated Telephone

( ) -

Fellowship Training Location

Year Attended/Graduated Telephone

( ) -

REFERENCES (please list at least two previous Supervisors/Managers)

Name & Relationship	Phone Number	Years Known
	( ) -	
	( ) -	
	( ) -	
	( ) -	
	( ) -	
	( ) -	

EMPLOYMENT HISTORY

Include military service- list last position first:

Employer | Date From | To

Address | City | State | Zip

Reason for Leaving

Employer | Date From | To

Address | City | State | Zip

Reason for Leaving

Employer | Date From | To

Address | City | State | Zip

Reason for Leaving

Please list any additional previous work experience on a separate sheet.

HOSPITAL PRIVILEGES

Hospital | Telephone ( ) -

Address | City | State | Zip

Type of Privileges

Hospital | Telephone ( ) -

Address | City | State | Zip

Type of Privileges

Hospital | Telephone ( ) -

Address | City | State | Zip

Type of Privileges

CURRENT MALPRACTICE INSURANCE CARRIER

Carrier | Telephone ( ) -

Address | City | State | Zip

LICENSURE AND BOARD CERTIFICATION

Are you currently Board Certified? ☐ Yes ☐ No
Which Board(s)?_____
Date Certified / /

Are you eligible to take Specialty Boards? ☐ Yes ☐ No When?_____

Which exam(s) have you taken? ☐ USMLE (Parts I, II, III) ☐ NBOME (Parts I, II, III)
☐ FLEX (1 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

Please list all professional associations with which you are affiliated

Please list any professional honors, awards, publications, or research

BACKGROUND

Have you ever been convicted of a crime?	☐ Yes ☐ No
Have you ever been the subject of a malpractice award or finding, or been named in a malpractice suit?	☐ Yes ☐ No
Have you ever been denied a license or had your license limited, suspended, denied, or revoked in any state?	☐ Yes ☐ No
Have your hospital or clinic staff privileges ever been limited, suspended, denied, or revoked?	☐ Yes ☐ No
Have you ever been involved in any other activity that would create doubt about your ability or right to practice?	☐ Yes ☐ No
Have you ever had your Drug Enforcement Administration Certificate or prescribing privileges limited, suspended, or revoked by any state or federal agency?	☐ Yes ☐ No
Is there any reason you could not practice full-time?	☐ Yes ☐ No
Is there anything preventing you from complying with any professional requirement?	☐ Yes ☐ No
Have you ever been discharged or requested to resign from any employment?	☐ Yes ☐ No
Have you ever been convicted of Medicare or Medicaid fraud?	☐ Yes ☐ No
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 above, 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	Printed Name

Date

/ /

PLEASE READ, SIGN AND DATE

Community Health Programs is committed to providing equal employment opportunity (EEO) for all persons regardless of race, color, sex, sexual orientation, religion, marital status, parental status, physical or mental disability, age, veteran status, ancestry, or national or ethnic origin, genetics, retaliation, sexual harassment, political beliefs, or any other basis prohibited by applicable state, federal or local laws.

The facts set forth in my application and attached resume are true and complete to the best of my knowledge. I understand that if employed, false statements or omissions on this application, my resume and all accompanying documents, are cause for termination, regardless of the time elapsed before discovery.

I authorize Community Health Programs (CHP), to check and verify all information provided in my application, and hereby release CHP and its agents and employees from any claims, charges, or liabilities whatever that may result from the verification process. Employment Eligibility Verification (E-verify) will be used to determine my eligibility to work in the United States. The E-verify information will be taken from my Form I-9. I understand that an offer of employment is contingent upon satisfactory proof of lawful employment status, as set forth in the Immigration Reform and Control Act of 1986 and reference and background checks. Permission is hereby given to CHP or any agent thereof to investigate previous employment, educational background and reference information including job performance, employment dates, and social media, etc.

I release CHP its subsidiaries and former employers from any liability resulting from any information provided in connection with this application.

Please note: CHP requires all employees to agree to and obtain a clear Criminal Offender Record Information (CORI) check as a condition of employment and as a Federally Qualified Health Care Center must not hire anyone on the US Department of Health and Human Services Office of Inspector General Exclusions List: http://oig.hhs.gov/fraud/exclusions.asp

CHP is a drug-free, alcohol-free, smoke-free work environment. Employees who work with children and/or work in CHP's medical clinics must agree to a tuberculosis skin test (also known as the tuberculin test or PPD test). Employees may be asked for additional tests/information depending on the job requirement. I understand that the receipt of this application does not imply that I will be employed. All employees of CHP are employees-at-will. This means CHP has the right to discontinue an employee's employment at any time at its discretion, with or without cause (but not for an illegal or discriminatory reason) and that you may leave at any time at your discretion. I understand that this employment application is not an expressed or implied employment contract.

I understand that the receipt of this application does not imply that I will be employed. I understand that this employment application is not an expressed or implied employment contract.

Applicant Signature _____

Date:

Equal Employment Opportunity Affirmative Action
Voluntary Self-Identification Form

Our company is an equal opportunity employer and does not discriminate in hiring or employment on the basis of race, color, religion, sex, national origin, age, disability, or any other basis prohibited by federal, state or local law. No question on this form is intended to secure information to be used for such discrimination.

We are subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, we invite our employees to voluntarily self-identify their race and ethnicity. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information will be kept confidential and will only be used in accordance with the provisions of applicable laws, executive orders and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

Date: / /

Applicant Name:_____

Applicant Signature: _____

☐ I understand the reason for this request for voluntary self-identification as stated above and choose to decline.

OR

☐ I understand the reason for this request for voluntary self-identification as stated above and have opted to complete this form.

Gender: ☐ Male ☐ Female

Race/Ethnicity:

☐ **Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race

☐ **White (Not Hispanic or Latino**): A person having origins in any of the original peoples of Europe, the Middle East or North Africa.

☐ **Black or African American (Not Hispanic or Latino):** A person having origins in any of the black racial groups of Africa.

☐ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino**): A person having origins in any of the peoples of Hawaii, Guam, Samoa or other Pacific Islands.

☐ **Asian (Not Hispanic or Latino):** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

☐ **American Indian or Alaskan Native (Not Hispanic or Latino):** A person having origins in any of the original peoples of North or South America (including Central America), and who maintain tribal affiliations or community attachment.

☐ **Two or More Races (Not Hispanic or Latino)**: All persons who identify with more than one of the above five races.

If you have any questions regarding this form, please contact the Human Resources Department.
Source: U.S. Equal Employment Opportunity Commission