Print Form

National Locum Solutions

Please complete the application in its entirety. If a question **does not apply** to you **write N/A**. If additional space is required in answering any section of the, attach all information on a separate sheet of paper.

Last Name _____ First Name _____ Middle Initial_____

Birth Name _____

Home Address_____ Apt # _____

City/Sate/Zip Code _____

Telephone # _____ Email: _____

Date of Birth _____ Place of Birth _____

Social Security # _____ Citizenship _____

Office Address _____ Office Telephone # _____

Stat License # _____ Federal ID # _____

Drivers License #_____ State _____

Degree: ☐ MD ☐ DO ☐ Other

Are you eligible to work in the United States? Yes ___ No ___

EMERGENCY CONTACT INFORMATION

Name: _____ Telephone # _____

Address: _____ Relationship _____

City, State, Zip Code: _____

MILITARY STATUS

Have you ever served in the United States Military? Yes ___ No ___

If yes, which branch? _____

Type of Discharge? _____

Are you a: Disabled veteran? _____

Veteran of the Vietnam Era? _____

Veteran (other)? _____ Please explain: _____

_____

SPECIALTY

Primary Practice Specialty: _____

Sub Specialties:_____

Other medical interests in practice (research, forensics, academics, etc.)_____

_____

When are you available to work? _____

Are you interested in permanent opportunities? _____

What type(s) of practice opportunities would you prefer?

In-patient ___ Out-patient ___ Urgent Care ___ Hospital ___ Solo Practice ___

Multi-Specialty Group ___ Clinic ___ Government Facility ___ Other ___

Do you have any geographic preferences? _____

Would you be willing to license in States that you are not currently licensed, should an interesting opportunity arise? _____

EDUCATION

Pre-Medical: _____

College/University: _____

Degree: _____

Honors: _____

Graduation Date: _____

Address: _____

MEDICAL EDUCATION

Medical School: _____ Degree _____

Address: _____

Dates Attended: (MM/DD/YY) _____ Graduation Date: _____

INTERNSHIP

Hospital/ Institution _____

Address _____

Dates Attended (MM/DD/YY) _____

Program Chairperson _____

Type of Internship _____

RESIDENCY

Hospital Institution _____

Address: _____

Dates Attended (MM/DD/YY) _____

Type of Residency _____

Program Chairperson _____

CONTINUED EDUCATION

Fellowship(s): _____

Institution: _____

Address: _____

Dates Attended (MM/DD/YY): _____

Program Chairperson: _____

Type of fellowship: _____

Board Certification(s): _____

Specialty/Board: _____ Certification Date: _____

Re-certification Date: _____ Board Eligibility _____

PROFESSIONAL ASSOCIATIONS / MEMBERSHIPS

List all professional associates and / or memberships that you are currently a member of:

_____

_____

_____

_____

WORK HISTORY

List Employers in reverse chronological order, beginning with the most recent employer. All dates from medical school to present must be accounted for. Should you have any gaps in your work history, list all dates and reasons on a separate sheet of paper. Also, if additional space is necessary, please attach on a separate sheet of paper.

Name of Institution: _____

Address _____

Telephone # _____

Dates Employed (MM/DD/YY) _____ Position _____

Name of Institution: _____

Address _____

Telephone # _____

Dates Employed (MM/DD/YY) _____ Position _____

Name of Institution: _____

Address _____

Telephone # _____

Dates Employed (MM/DD/YY) _____ Position _____

Name of Institution: _____

Address _____

Telephone # _____

Date Employed (MM/DD/YY) _____ Position _____

Reason for leaving most recent employer?

_____

_____

_____

HOSPITAL AFFILIATION

List all hospital affiliations; in reverse chronological order, beginning with the most recent. If additional space is required, include a separate sheet of paper.

Name of Hospital: _____

Telephone #: _____

Address: _____

Staff Category: _____ Dates (MM/DD/YY): _____

Name of Hospital: _____

Telephone #: _____

Address: _____

Staff Category: _____ Dates (MM/DD/YY): _____

Name of Hospital: _____

Telephone #: _____

Address: _____

Staff Category: _____ Dates (MM/DD/YY): _____

Name of Hospital: _____

Telephone #: _____

Address: _____

Staff Category: _____ Dates (MM/DD/YY): _____

LICENSES

List all current and past medical licenses.

State: _____ License number: _____ Issue Date: _____ Expiration Date: _____

(Attach copies of all licenses. Please list any additional licenses on a separate sheet of paper. If a substance control number is required for any of the states listed above, attach copies with the license.)

UPIN Number: _____ ACLS: _____ ATLS: _____ BLS PALS: _____

D.E.A Registration Number: _____ Issue Date: _____

Expiration date: _____

LICENSURE AND CLAIMS HISTORY

(** If you answer "Yes" to any question, please provide a detailed explanation on a separate sheet of paper.**)

1. Have you ever been the subject of disciplinary or investigative proceedings or reprimanded by a governmental, administrative agency, hospital or professional association?
   Yes ☐ No ☐

2) Have you ever had any State professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or voluntary surrender of same? Yes ☐ No ☐

3) Have your hospital privileges and / or professional services ever been denied, revoked, suspended, refused, limited, placed on probation, or placed under and disciplinary action?
   Yes ☐ No ☐

4) Have there been or are there any pending malpractice claims, judgments, suits, settlements, or notice of intent to commence action involving you and / or your medical practice?
   Yes ☐ No ☐

5) Have you ever been convicted of an act committed in violation of any law or ordinance other than a traffic violation? Yes ☐ No ☐

6) Do you have now or have you ever had any problems with or been treated for drug or alcohol dependency? Yes ☐ No ☐

7) Have you ever had any professional liability insurance company cancel, decline, refuse to renew, or accept only on special terms, their malpractice insurance? Yes ☐ No ☐

HEALTH STATUS

Have you ever had or do you now have any physical or mental condition that would compromise your ability to practice medicine or perform clinical assignments? ☐ Yes ☐ No

PROFESSIONAL REFERENCES

Provide at least (3) three references from physicians who have had clinical contact with, and are capable of assessing your professional skills within the past 18 (eighteen) months.

Reference: _____

Address: _____

Telephone: _____ E-mail: _____

Reference: _____

Address: _____

Telephone: _____ E-mail: _____

Reference: _____

Address: _____

Telephone: _____ E-mail: _____

Reference: _____

Address: _____

Telephone: _____ E-mail: _____

Reference: _____

Address: _____

Telephone: _____ E-mail: _____

AUTHORIZATION AND WARRANTY

I **authorize** the release of all information from **Medical Schools, Colleges, Universities, Medical Institutions, Hospitals, Clinics, Physicians, State Medical Boards, Medical Malpractice Carriers, All Government Agencies, and any other source necessary** to assist with my credentialing process.

I understand that all information will be used to **evaluate my professional qualifications, assist with credentialing at Health Care Facilities, and for use when applying to State Medical Boards for licensing are necessary.**

_____ _____

Signature **Date**

_____

Print Name