

Locum Physicians, LLC

1631 Rock Springs Road
 Suite 120
 Apopka, FL 32712
 Toll Free 1-855-GO-LOCUM (855-465-6286)
 www.Locum-Physicians.com

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 APPLICATION, ATTACH ALL INFORMATION ON A SEPARATE SHEET OF PAPER.

Last Name	First Name	Middle Initial	Birth Name
Home Address			Apartment Number
City / State / Zip Code		Telephone Number	Email Address
Date of Birth		Place of Birth	
Social Security Number		Citizenship	
Office Address _____ _____ Suite # _____			Office Telephone Number _____ Federal I.D. Number _____ Degree: <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Other
City _____ State _____ Zip Code _____			
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Name of Spouse / Domestic Partner	
Are you eligible to work in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No			

EMERGENCY CONTACT INFORMATION

Name _____	Telephone Number
Address _____ _____	Relationship
City _____ State _____ Zip Code _____	

MILITARY STATUS

Have you ever served in the United States Military? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what branch?	Type of discharge?
Are you a: Disabled Veteran? _____ Veteran of the Vietnam Era? _____ Veteran (other)? _____	Please Explain: _____

Applicant's Printed Name _____

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? <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Urgent Care <input type="checkbox"/> Hospital <input type="checkbox"/> Solo Practice <input type="checkbox"/> Multi-Specialty Group <input type="checkbox"/> Clinic <input type="checkbox"/> Government Facility <input type="checkbox"/> 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:
Date of Graduation:
Address: Claremont,

MEDICAL EDUCATION

Medical School:	Degree:
Address:	

Dates Attended	Date of Graduation:
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INTERNSHIP

Hospital / Institution:	
Address:	
Dates Attended (MM/DD/YY):	
Type of Internship:	Program Chairperson:

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):	
Type of Fellowship:	Program Chairperson

Applicant's Printed Name _____

Board Certification(s)		
Specialty/Board	Certification Date	Re-certification Date
Board Eligibility:		

CONTINUING MEDICAL EDUCATION (CME's)

Provide a list of all CME activities for which you have received credits in the past 2 years.

PROFESSIONAL ASSOCIATIONS / MEMBERSHIPS

List all professional associations and / or memberships that you are currently a member of.

WORK HISTORY

List 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:	Telephone Number:
Address:	
Dates Employed (MM/DD/YY):	Position:

Name of Institution:	Telephone Number:
Address:	
Dates Employed (MM/DD/YY):	Position:

Name of Institution:	Telephone Number:
Address:	
Dates Employed (MM/DD/YY):	Position:

Name of Institution:	Telephone Number:
Address:	
Dates Employed (MM/DD/YY):	Position:

Reason for leaving most recent employer:

HOSPITAL AFFILIATIONS

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 Number:
Address:	
Staff Category:	Dates (MM/DD/YY):

Name of Hospital:	Telephone Number:
Address:	
Staff Category:	Dates (MM/DD/YY):

Applicant's Printed Name _____

Name of Hospital:	Telephone Number:
Address:	
Staff Category:	Dates (MM/DD/YY):

Name of Hospital:	Telephone Number:
Address:	
Staff Category:	Dates (MM/DD/YY):

EXAMINATIONS/ LICENSES

Which exam did you take to get your original license? (USMLE, State Boards, Flex, etc.)	
Number of times taken?	Dates of completion?

What other licensing exams have you taken? Please list.			
	Exam	Number of Times Taken	Date of Completion
1)			
2)			
3)			
4)			

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.)

NPI Number	ACLS	ATLS	BLS	PALS
D.E.A. Registration Number:	Issue Date:	Expiration Date:		

*****ATTACH A COPY*****

Professional Liability Insurance	
Insurance Carrier:	Policy Number:
Address:	Telephone Number
Coverage Limits	Expiration Date

Insurance Carrier:	Policy Number:
Address:	Telephone Number
Coverage Limits	Expiration Date

Insurance Carrier:	Policy Number:
Address:	Telephone Number
Coverage Limits	Expiration Date

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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 reprimand 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 notices 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 (6) SIX REFERENCES FROM PHYSICIANS WHO HAVE HAD CLINICAL CONTACT WITH, AND ARE CAPABLE OF ASSESSING YOUR PROFESSIONAL SKILLS, **WITHIN THE PAST 12-24 MONTHS.**

Applicant's Printed Name _____

ATTESTATION AND AUTHORIZATION

I **certify** that the information on this application is true and complete to the best of my knowledge. I **authorize LOCUM PHYSICIANS, LLC** to release information contained in this application to its **Risk Management Department, insurance companies, and medical facility clients.**

I hereby **authorize** the disclosure by **any institution (including but not limited to the Federation of State Medical Boards and State Licensing Boards)** information regarding me, including my **education, medical training and employment, skills, experience, fitness to practice medicine, character, work habits, job performance, certification, licensure, hospital staff or clinical privileges, DEA authorization and medical malpractice claims.** The undersigned releases the above from any claims resulting from the disclosure of such opinions to **LOCUM PHYSICIANS, LLC.**

SIGNATURE

DATE

PRINT NAME

Locum Physicians, LLC

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Applicant's Printed Name _____

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 licensure are necessary.**

SIGNATURE

DATE

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DECLARATION HEALTH

I, _____, hereby declare that, to the best of my knowledge, I do not have a **physical or mental condition that would adversely affect my ability to carry out the clinical privileges**, which I have requested as a Locum Tenens physician.

Signature

Date

CONFIRMATION OF APPLICANT'S DECLARATION

I concur with the Declaration of Health presented by:

(Applicant's Name)

Signature _____
Physician

Date

Name _____

Address _____

Telephone _____

Fax _____

Applicant's Printed Name _____

HEPATITIS B VACCINE

DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis-B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis-B vaccination.

- I have already been vaccinated with the Hepatitis-B vaccine (date) _____, at (where: facility, city, state) _____, and therefore decline Hepatitis-B vaccination at this time. (Attach a copy of your immunization record or physician's statement.
- I decline Hepatitis-B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis-B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at that time.

Name (Please Print)

Signature

Date

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License/Credentials Certification

I hereby certify the following:

My license to provide health care services has neither been revoked within the last 10 years, nor is it currently suspended by any state licensing authority for reasons bearing on professional competence, professional conduct or financial integrity;

I am **NOT** currently excluded, suspended or otherwise barred from participation in the Medicare of Medicaid programs or any other Federal or Federally-assisted program;

I have **NOT** currently surrendered my license while formal disciplinary proceeding involving professional conduct is pending;

And,

I will immediately notify the Recruiter and/or Credentialing Coordinator of Locum Physicians, Inc. if any of the following situations occur:

- My license lapses for any reason or I fail to renew my license when it expires;
- My license to provide medical or health care services is revoked or suspended by any state licensing authority for reasons bearing on professional competence, professional conduct or financial integrity;
- I am excluded, suspended or otherwise barred from participation in the Medicare or Medicaid programs or any other Federal or Federally-assisted programs; and
- I am asked to surrender my license while formal disciplinary proceeding involving professional conduct is pending.

Date

Signature

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