



LOCUM TENENS PHYSICIAN APPLICATION

Identifying Information	Last Name	First Name	Middle Name	Maiden Name
	Office Address	City	County	State zip code telephone
	Home Address	City	County	State zip code telephone
	Email Address	Date Of Birth		Birthplace
	NPI Number	Medicare Number	Medicaid State & Number	
	Citizenship/VISA status		Social Security Number	
	Marital Status	Name Of Spouse	No. of children	
	Practice Limited To			
	Practicing With Whom And Nature Of Affiliation			
Pre-Medical Education	College/University	Degree	Honors	
	Address		Date of Graduation (Mo/day/yr)	
Medical Education	Medical School	Degree		
	Address	Date Of Graduation (mo/day/yr)		
Internship	Hospital	Dates (FROM: (mo/day/yr) TO: mo/day/yr)		
	Address	Type of Internship		
	Practitioners Responsible for Performance (Chief of Staff, Chairperson of Dept., Others)			
Residency and/or Fellowship or other Graduate Education	Institution	Responsible Practitioner Dates		
	Address			
	Institution	Responsible Practitioner Dates		
	Address			

Continuing Medical Education	List all postgraduate activities which you have attended, or for which you have received credit in the past two years. Attach list to application.
	Submit a list of scientific papers or essays you have written and list scientific meetings you have attended during previous three years (include reprints).
Hospital Affiliations	Facility/Practice Dates (FROM: (mo/day/yr) TO: mo/day/yr)
	Address
	Facility/Practice Dates (FROM: (mo/day/yr) TO: mo/day/yr)
	Address
	Facility/Practice Dates (FROM: (mo/day/yr) TO: mo/day/yr)
	Address
	Facility/Practice Dates (FROM: (mo/day/yr) TO: mo/day/yr)
	Address (Add an additional sheet, if necessary)
Additional Affiliations	Attach a resume or list on a separate sheet of paper all previous hospital affiliations and medical staff memberships in chronological order that are not listed above. Include assistantships and appointments. Specify all departments in which privileges were exercised and nature and extent of such privileges.
Professional Societies	List current professional society memberships societies
Fellowship Or Membership	American College of
	American College of
	Other Specialty Colleges membership Date
Certification	BC (Board Certified) Date
	BE (Board Eligible) Date
	Specialty Board Status (Name of Board)
	BCLS Exp. Date
	ACLS Exp. Date
	ATLS Exp. Date
	PALS Exp. Date
	NRP/NALS Exp. Date
	ALSO Exp. Date
	MQSA Exp. Date

Licensing (Attach copies of all active licenses. List any additional licenses on a separate sheet, if necessary. Include any Foreign licenses.)	Medical License (State)	Issue Date (Mo/Day/Yr)	Expiration Date (Mo/Day/Yr)	License No.
	Medical License (State)	Issue Date (Mo/Day/Yr)	Expiration Date (Mo/Day/Yr)	License No.
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	List any <i>inactive</i> licenses, and numbers			
	National Provider Identification Number (NPI)			
	Federal Narcotics Registration Number (Attach a copy)	Issue Date (Mo/Day/yr)	Expiration Date (Mo/Day/Yr)	
	State Narcotics Registration Number (Attach a copy)	Issue Date (Mo/Day/yr)	Expiration Date (Mo/Day/Yr)	
Exam History	Pre-1985 FLEX (How Many Times?)		When Was Most Recent (Mo/Yr)	
	FLEX Component I (How Many Times?)		When Was Most Recent (Mo/Yr)	State
	FLEX Component II (How Many Times?)		When Was Most Recent (Mo/Yr)	State
	USMLE Step 1 (How Many Times?)		When Was Most Recent (Mo/Yr)	State
	USMLE Step 2 (How Many Times?)		When Was Most Recent (Mo/Yr)	State
	USMLE Step 3 (How Many Times?)		When Was Most Recent (Mo/Yr)	State
	SPEX (How Many Times?) When Was Most Recent (Mo/Yr)			State
	NBME		Identification (Certificate) Number	State
	EDFMG (Certificate Number)		Issue Date (Mo/Yr)	State
References	Doctor	Complete Address		Telephone Number
				Email
	Doctor	Complete Address		Telephone Number
				Email
Doctor	Complete Address		Telephone Number	
			Email	
Doctor	Complete Address		Telephone Number	
			Email	
Malpractice Insurance	Amount of Malpractice Coverage		Malpractice Carrier	
	Policy No.			

Malpractice Underwriting Information

1. Have you ever been involved in a malpractice claim or suit either directly or indirectly? Yes No

If 'yes', complete supplementary claim information on separate sheet. Please list each claim separately. Indicate all relevant details, including name of claimant, date of incident, a brief description of treatment and all allegations made against you; other defendants involved; insurer defending you; plus disposition of claim and amount of judgment or settlement paid in your behalf.

2. Do you have knowledge of any pending claims or activities that might give rise to a claim in the future?

Yes No If 'yes', have you notified your current insurer? Yes No

3. Have you ever had professional liability insurance refused, declined, cancelled or accepted on special terms? Yes No

If 'yes', please explain: _____

4. Performance

- a. Have you ever been involved with, or received treatment for alcohol or drug abuse or are you currently involved in any illegal drug use? Yes No
- b. Are there any reasons you are unable to perform the functions of a physician, with or without accommodations? Yes No
- c. Have you ever been convicted or are you currently under investigation of felony charges? Yes No
- d. Has your narcotics, medical license, or any other license or registration, in any jurisdiction, ever been denied, put on probation, limited, suspended, revoked or surrendered? Yes No
- e. Have you ever been denied a medical license, certification by a specialty board, or membership in any professional society or association, or been subject to disciplinary action by any medical organization? Yes No
- f. Have your existing clinical privileges at any hospital or facility ever been suspended, revoked, diminished, refused, not renewed or surrendered? Yes No
- g. Have you ever voluntarily or involuntarily surrendered your hospital privileges, or your narcotics or medical license, to avoid suspension, restriction, probation or revocation? Yes No
- h. Have you ever been the subject of any investigation by any private or government agency concerning your participation in any Medicare or Medicaid program? Yes No
- i. Have you ever had a complaint filed against you with your Medical Society or association Foundation, Local or Federal Government Authority (e.g. Board of Medical Examiners of any state, Medicare, etc.)? Yes No
- j. Have you ever, received a Decree of Censure from the Board of Medical Examiners* (of any state) or are you under the Board's Probation or Stipulation? Yes No

Professional History

For any "yes" answers to any or the following question, please give full details on a separate sheet of paper.

	Yes	No
1. Has your license or certification in any jurisdiction ever been limited, suspended, revoked or voluntarily withdrawn?	_____	_____
2. Have your privileges or professional services at any hospital ever been suspended, diminished, revoked, not renewed, voluntarily limited, or reduced (per hospital decision)?	_____	_____
3. Have you ever been denied membership or renewal thereof, been subject to disciplinary action (either voluntarily or involuntarily) in medical organization or medical staff	_____	_____
4. Have you ever been refused and/or dropped by a medical liability insurance carrier for any reason?	_____	_____
5. Have you ever been involved as a respondent in any professional liability action other than as a witness? If so, are there any judgments or settlements past or pending against you?	_____	_____
6. Have you ever been charged with/convicted of a felony?	_____	_____
7. Have you experienced any problems with or been treated for drug or alcohol dependency?	_____	_____
8. Have you ever had any administrative sanctions or been suspended from participating in Title 18 (Medicare) or Title 19 (Medicaid) or are there any pending?	_____	_____

ATTESTATION STATEMENT

I certify that the information on this application is true and complete to the best of my knowledge. I authorize Eskridge & Associates. to release information contained in this application, or obtained by Eskridge & Associates pursuant to its credentials verification processes also authorized by this paragraph, to its credentials verification organization, insurance companies, and medical facility clients. I waive any claims I might otherwise have against Eskridge & Associates for releasing information as authorized by this paragraph.

Signature of Applicant: _____

Date: _____

Physician Documents Check List

If an item is not applicable to you, please enter line through that item.

Please include the following documents with your Application:

- Current Curriculum Vitae (all gaps in CV from Medical School to present must be accounted for)
- Completed Application
- Copy of Medical Diploma
- Copy of Internship Certificate
- Copy of Residency Certificate(s)
- Copy of Fellowship Certificate(s)
- Copy of E.C.F.M.G. Certificate (If Applicable)
- One Copy each of all current State Medical License Cards
- One copy each of current State Controlled Substance Certificates
- ACLS/BLS
- One copy of your Federal D.E.A. Certificate
- One copy of any state-specific prescription certificate
- One copy of your Board Certification (s)
- Any yes answers must be accompanied by a complete explanation from you. This applies to cases and disciplinary actions both past and present. If there was a settlement in your name we will need the amount and insurance company and broker information.

****Please make copies of all documents and application for your records.****



RELEASE AUTHORIZATION

I hereby authorize all hospitals, medical institutions or organizations, personal references, employers (past and present), business and professional associates (past and present), all governmental agencies and instrumentalities (local, state, federal, or foreign), all university transcript offices, all medical schools and the Federation of State Medical Boards, state licensing boards to release to Eskridge & Associates any information, files, or records required by Eskridge & Associates for its evaluation of my professional, ethical and physical qualifications for credentialing.

Physician's Signature

Printed Name

Date