Application Checklist

- ☐ Completed & Signed Application
- ☐ Signed Release & Authorization
- ☐ Copy of Curriculum Vitae –must include a complete chronology of activities within the last 2 years(all gaps must be accounted for).

Additional Documentation MAY be Required:

- ☐ W-9 if changes have occurred within the last 2 years
- ☐ 1st and 3rd party documentation if claims have been made in the last 2 years
- ☐ Copy of Current TB Test

PHYSICIAN
REAPPOINTMENT
APPLICATION

Personal Information

Last Name MD/DO	First Name	Middle Name	Previous Surname	Suffix

NPI Number	Date of Birth*	Social Security Number

Birth City	Birth State/Province	Birth Country

Preferred Address

Address	Apt / Unit Number

City	State/Province	Zip Code	Country

Home Phone Number	Work Phone Number	Mobile Number

Primary Email Address	Secondary Email Address

Disciplinary Actions, Sanctions, Limits *If your answer is* **"Yes"** *to any of the following questions, please provide full details on a separate sheet.*

Question	Answer
Have any of your professional licenses, in **ANY** state, been limited, sanctioned, voluntarily/involuntarily restricted, denied, revoked, suspended, surrendered, subjected to a consent order, placed on probation, withdrawn, conditioned or cancelled within the last 2 years? **IF YES:** Date of Occurrence:______________ Total Claim Payment:______________ **Claim Outcome:**(Circle One) Pending Withdrawn by Claimant Dismissed/Settled/Closed-no Payment Dismissed/Settled/Closed-w/Payment **Provider Case Narrative:**	Yes No
Has your DEA license or your state CDS certification been voluntarily or involuntarily suspended, restricted, revoked, surrendered, withdrawn, terminated or voluntarily surrendered within the last 2 years?	Yes No
Have any of your board certifications been suspended, revoked, restricted, limited, terminated, withdrawn or placed on probation within the last 2 years?	Yes No
Have your privileges/affiliations at **ANY** hospital, facility, or managed care organization been voluntarily or involuntarily surrendered, denied, suspended, revoked, restricted, limited, terminated, withdrawn or placed on probation within the last 2 years?	Yes No
Have you been named as a defendant in **ANY** criminal case, other than a misdemeanor traffic violation within the last 2 years?	Yes No
Have you been suspended from or sanctioned by the Medicare, Medicaid, or any other program funded with federal, state, or local monies, or has your participation status in any such program **EVER** been modified (terminated, suspended, restricted, revoked, limited, cancelled, conditioned, or **ANY** other adverse action)within the last 2 years?	Yes No
Have you been the subject of a focused review by a peer review organization or similar agency including, but not limited to, Medicare, Medicaid, etc. within the last 2 years? If yes, please provide details on a separate sheet of paper.	Yes No
Have you been sanctioned or otherwise disciplined for a violation of ethical standards, rules or guidelines by a professional organization, licensing board, or healthcare organization within the last 2 years?	Yes No
Has your malpractice insurance been cancelled, suspended, restricted, limited, specially rated, or not renewed within the last 2 years?	Yes No
Have you been sanctioned, reprimanded, censured or otherwise disciplined in **ANY** manner by any federal, state or local licensing authority or other professional board or peer committee for conduct related to the use or abuse of alcohol or drugs within the last 2 years?	Yes No
Has information pertaining to you been reported to the National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protection Data Bank (HIPDB) within the last 2 years? If yes, please provide number of cases________ and first and third party supporting documentation	Yes No

Health Status *If your answer is* **"Yes"** *to any of the following questions, please provide full details on a separate sheet.*

Question	Answer
Are there any reasons that would prevent you from being able to perform the job-related functions of a locum tenens physician competently?	Yes No
Do you currently have any chemical substance abuse dependency?	Yes No

Board Certifications-If certified since last application

Name of specialty board	Certified	Date (mm/yyyy)	Recertified?	Date (mm/yyyy)
	Yes No		Yes No	

NOTEProfessional license information will be obtained by the Federation of State Medical Boards for reappointment**

Professional References *Please list at least three professional references within your specialty with whom you have had CLINICAL contact in the past two years. They must be able to assess your professional skills and capabilities. Verbal references will be kept confidential. When possible, please let your reference know that an agent of Medestar will be calling. If you are just completing a residency or internship, please list your program chair. If you are unable to provide two same specialty references, a written explanation is required.*

Name	Position	Work Phone	Fax
Email address	Primary Specialty	Worked with from(mm/yr)and to(mm/yr	Home Phone
Name	Position	Work Phone	Fax
Email address	Primary Specialty	Worked with from(mm/yr)and to (m/yr)	Home Phone
Name	Position	Work Phone	Fax
Email address	Primary Specialty	Worked with from(mm/yr) to (mm/yr)	Home Phone

Hospital Privileges/Current and Past- *List all locations you currently have hospital privileges or any additional privileges obtained within the last 2 years.*

Facility Name	City	State	Zip Code
Type of Privileges	From		To
Facility Name	City	State	Zip Code
Type of Privileges	From		To
Facility Name	City	State	Zip Code
Type of Privileges	From		To
Facility Name	City	State	Zip Code
Type of Privileges	From		To

Professional Liability Insurance *List all carriers for the past two (or current hospital affiliations). Attach additional pages if necessary.*

Present Carrier	Policy Number

Consent

I hereby affirm and acknowledge that the information provided by me on this application and the attachments is true, complete and correct, and that Medestar will rely on the truthfulness of my statements in evaluating my potential to be placed with Medestar's clients as a Locum Tenens provider. I hereby release Medestar, its staff, representatives and agents from liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I further release from liability physicians, hospitals and other references for the good faith release of information regarding my professional capabilities

By providing your name, signature, and phone numbers you are consenting to receive phone calls from Medestar and its affiliates regarding our services.

Provider's Signature **Date**

Release and Authorization

By my signature below, I authorize Medestar to confirm information contained on any document that I provide to Medestar, including my curriculum vitae, and to conduct background and reference checks on me regarding any information related to possible placement as a locum tenens provider. This includes information on my education, licensing, work history, Medicare/Medicaid sanctions, malpractice claims and insurance eligibility. Medestar may gather the information from various sources including, but not limited to, consumer reporting agencies, hospitals, medical institutions or organizations, personal references, physicians, employers (past and present), business and professional associates (past and present), governmental agencies and instrumentalities (local, state, federal, or foreign), university transcript offices, medical schools, the Office of Inspector General and the Federation of State Medical Boards.

I consent to Medestar sharing this information with Medestar clients and affiliates, government or other licensing entities, or professional liability insurers. I understand that, upon my request, Medestar will disclose to me the nature and substance of the information in accordance with federal law. A request for disclosure of information must be made in writing and directed to my Recruiting Consultant.

I authorize the above-named entities and individuals to release to state licensing boards, hospitals, and Medestar any information (written or oral), including medical information, files or records about me in their possession required for evaluation of my qualifications for placement as a locum tenens provider. I hereby release the above-named individuals and entities, including Medestar and its agents, from liability or damages that may result from the release of information described above.

I am signing this release for the purpose of allowing Medestar to assist in my request for a license to practice in my profession and to assist in my efforts to work as a locum tenens provider for Medestar's clients.

Date

Printed Name

Signature

Employee Name______________________ **Job Title**__________________

Social Security #_____-____-___________ **Date of Birth** _______________

Please indicate your answer to each question. This information is necessary to correctly interpret the result of your tuberculin skin test, or in some cases may indicate you should not receive a tuberculin skin test

	Yes	*No*
1. Have you ever had a positive tuberculin skin test? If yes, what month and year?	____	____
2. Have you ever taken medications for the prevention or treatment of tuberculosis? If yes, what year were they taken? __________ How long did you take them? _____________	____	____
3. Are you an organ transplant recipient?	____	____
4. Have you ever had an abnormal chest x-ray suggestive of tuberculosis or evidence of latent disease?	____	____
5. Have you taken steroids, immunosuppressants or cancer drugs in the past 30 days?	____	____
6. Have you received a live vaccine (MMR< Varicella, Flumist) within the past 30 days?	____	____
7. Are you allergic or medically contraindicated to the Mantoux PPD skin test?	____	____
8. Were you born outside of the United States? If so, what country? _______________		

Please check any of the following symptoms you are currently experiencing that are unrelated to prior health issues:

- Fever
- Shortness of breath
- Chest pain
- Night Sweats
- I have no symptoms
- Unintentional weight loss
- Chronic Cough
- Sputum (productive cough)
- Bloody Sputum
- Loss of appetite
- Unusual Fatigue

By signing below, I attest that all answers above are true and correct to the best of my knowledge. I understand that if a tuberculin skin test is placed it must be read between 48-72 hours after placement. I further affirm that any questions or concerns have been answered to my full satisfaction and I consent to receiving the tuberculin skin test (TST) at this time.

Employees Signature:__________________________Date: ___________________