PHYSICIAN 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

*Used for verification purposes only. Medestar does not discriminate on the basis of age or other factors.

Primary Practice Specialty	Secondary Practice Specialty

Are you able to work legally in the United States? ◯ YES ◯ NO
If yes, please indicate the following: ◯ US Citizen ◯ Visa or Work Authorization (You may be asked to provide proof of eligibility.)

Emergency Contact	Relationship to you	Phone Number

Other than English, list all languages you speak

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, **EVER** been limited, sanctioned, voluntarily/involuntarily restricted, denied, revoked, suspended, surrendered, subjected to a consent order, placed on probation, withdrawn, conditioned or cancelled?	◯ Yes ◯ No
Has your DEA license or your state CDS certification **EVER** been voluntarily or involuntarily suspended, restricted, revoked, surrendered, withdrawn, terminated or voluntarily surrendered?	◯ Yes ◯ No
Have any of your board certifications **EVER** been suspended, revoked, restricted, limited, terminated, withdrawn or placed on probation?	◯ Yes ◯ No
Have your privileges/affiliations at **ANY** hospital, facility, or managed care organization **EVER** been voluntarily or involuntarily surrendered, denied, suspended, revoked, restricted, limited, terminated, withdrawn or placed on probation?	◯ Yes ◯ No
Have you **EVER** been placed on probation, asked to resign or actually resigned from an internship, residency, or **ANY** other training program?	◯ Yes ◯ No
Have you **EVER** been named as a defendant in **ANY** criminal case, other than a misdemeanor traffic violation?	◯ Yes ◯ No
Have you **EVER** 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)?	◯ Yes ◯ No
Have you **EVER** been the subject of a focused review by a peer review organization or similar agency including, but not limited to, Medicare, Medicaid, etc.?	◯ Yes ◯ No
Have you **EVER** been sanctioned or otherwise disciplined for a violation of ethical standards, rules or guidelines by a professional organization, licensing board, or healthcare organization?	◯ Yes ◯ No
Has your malpractice insurance **EVER** been cancelled, suspended, restricted, limited, specially rated, or not renewed?	◯ Yes ◯ No
Have you **EVER** 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?	◯ Yes ◯ No
Has information pertaining to you **EVER** been reported to the National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protection Data Bank (HIPDB)?	◯ Yes ◯ No

Professional Liability

Have you **ever** been involved in a malpractice claim(s) (including dismissed actions)? ◯ Yes **(If yes, how many?____ Attach Supplemental Claims Form for each.)** ◯ No

Has any monetary payment ever been made by you or on your behalf because of alleged medical malpractice? ◯ Yes ◯ No

Are there any pending medical malpractice claims or settlements involving yourself? ◯ Yes ◯ No

Has your professional liability insurance coverage ever been denied, limited, or canceled by the action of any insurance company? ◯ Yes ◯ No
If Yes, attach explanation on a separate sheet.

Has your current liability insurance coverage carrier excluded any specific procedures from your insurance coverage? ◯ Yes ◯ No
If Yes, list excluded procedures with full explanation and dates of limitations on a separate sheet.

Health Status

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

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

Undergraduate Education

College or University		Degree
City	State / Province	Date of graduation (mm/yyyy)

Medical/Osteopathic Education

Medical/Osteopathic School		Phone #	
Address	City, State/Province	Zip Code	Country
Degree	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Date of graduation (mm/yyyy)

Internship

Facility Name		Phone #	
Address	City, State/Province	Zip Code	Country
Specialty	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Did you successfully complete the program? ◯ **Y / N** ◯

Residencies

Facility Name		Phone #	
Address	City, State/Province	Zip Code	Country
Specialty	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Did you successfully complete the program? ◯ **Y / N** ◯
Facility Name		Phone #	
Address	City, State/Province	Zip Code	Country
Specialty	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Did you successfully complete the program? ◯ **Y / N** ◯

Fellowships

Facility Name		Phone #	
Address	City, State/Province	Zip Code	Country
Specialty	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Did you successfully complete the program? ◯ **Y / N** ◯
Facility Name		Phone #	
Address	City, State/Province	Zip Code	Country
Specialty	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Did you successfully complete the program? ◯ **Y / N** ◯

Board Certifications

Name of specialty board	Certified	Date (mm/yyyy)	Recertified?	Date (mm/yyyy)
	Yes No		Yes No	
	Yes No		Yes No	
If not BC, have you been accepted to take a specialty examination? Date scheduled:________________________	Yes No	If you are not BC, how many times have you taken a specialty board examination and failed to pass? ___________________		

ECFMG / FMGEMS Yes No (If yes, please complete this section.)

Certificate Number	Date issued (mm/yyyy)

Fifth Pathway Education Yes No (If yes, please complete this section

Institution	Phone #			
Address	City, State/Province	Zip Code	Country	
Major	Program completed ☐ Yes ☐ No (If no, please explain on separate sheet)	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Date of completion

Military Service Yes No (If yes, please complete this section.)

Branch	Start Date (mm/yyyy)	End Date (mm/yyyy)
Status: Active Honorable Discharge Dishonorable Discharge Other (please specify)		

Federation Credentials Verification Services Yes No (If yes, please complete this section.)

Do you have a packet established with FCVS?	Yes No	If so, please list Packet ID

Professional Licenses & Controlled Substance Permits **Please list all, active and inactive, state medical licenses and state controlled substance permits.*

State	License Number	Date Issued	Exp Date	Controlled Substance Permit Number	Date Issued	Exp Date

DEA Registration Yes No (If yes, please complete this section.)

Registration Number	Date Issued	Expiration Date
Registration Number	Date Issued	Expiration Date
Registration Number	Date Issued	Expiration Date
If you do not possess a DEA Registration, please explain here:		

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

Present Carrier	Policy Number			
Coverage Limits	Expiration Date	Years with company		
Address	City	State/Province	Zip Code	Country
Previous Carrier	Policy Number			
Coverage Limits	Expiration Date	Years with company		
Address	City	State/Province	Zip Code	Country
Previous Carrier	Policy Number			
Coverage Limits	Expiration Date	Years with company		
Address	City	State/Province	Zip Code	Country

Licensing Examinations

☐ USMLE ◯ ☐ FLEX ◯ ☐ National Board ◯ ☐ State Exam ◯	In which state?	# of times taken?	Last taken?

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
Address			Primary Practice Specialty	Email		Home Phone
City	State/Province	Zip		Country	Worked with from (mm/yy)	Worked with to (mm/yy)
Name			Position	Work Phone		Fax
Address			Primary Practice Specialty	Email		Home Phone
City	State/Province	Zip		Country	Worked with from (mm/yy)	Worked with to (mm/yy)
Name			Position	Work Phone		Fax
Address			Primary Practice Specialty	Email		Home Phone
City	State/Province	Zip		Country	Worked with from (mm/yy)	Worked with to (mm/yy)

Hospital Privileges/Current and Past- *List all locations you currently have/held hospital privileges. Attach additional pages if necessary.*

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	

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 it's affiliates regarding our services.

______________________________ ______________________________

Provider's Signature **Date**