



PHYSICIAN APPLICATION

DOCUMENTS TO SUBMIT WITH APPLICATION:

- Curriculum Vitae
- Completed Physician Application
- Completed Physician Contact Information Form
- Signed Carolina Locum Resources Provider Locum Tenens Agreement
- Copy of North Carolina license
- Copy of North Carolina license registration
- Copy of current DEA registration
- Copy of ACLS/ATLS/BLS/NALS/ PALS/ NRP certificates (if applicable)
- Copy of NPI (National Provider Identifier) Number
- Copy of Social Security Number for accounting purposes
- Clear copy of Drivers License
- 2 Reference letters and/or reference contact information
- Voided check for direct deposit (optional)

IDENTIFYING INFORMATION

Last Name		First name	Middle name	Previous Surname	Suffix
Degree <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> MBBS <input type="checkbox"/> Other (please specify)					Social Security Number
		NPI Number		Date of Birth*	
Birth City		Birth State / Province		Birth Country	
Primary Practice Specialty			Secondary Practice Specialty		
Are you able to work legally in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please indicate the following: <input type="checkbox"/> US Citizen <input type="checkbox"/> Visa or work authorization <i>(You may be asked to provide proof of eligibility to work in the US.)</i>					
Other than English, list all languages you speak					

*Used for credentials verification purposes only. Carolina Locum Resources does not discriminate on the basis of age or other factors.

PREFERRED ADDRESS

Address		Apt / Unit Number	Email	
City	State / Province	Zip Code	Country	
Home Phone Number	Work Phone Number	Cell Phone Number		

PROFESSIONAL LIABILITY

Have you ever been involved in a malpractice claim(s) (including dismissed actions)? <input type="checkbox"/> Yes (If yes, how many? _____ Attach Supplemental Claims Form for each.) <input type="checkbox"/> No	
Has any monetary payment ever been made by you or on your behalf because of alleged medical malpractice? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are there currently any pending medical malpractice claims or settlements involving yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has your professional liability insurance coverage ever been denied, limited, or canceled by the action of any insurance company? If Yes, attach explanation on a separate sheet. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your current liability insurance carrier excluded any specific procedures from your insurance coverage? If Yes, list excluded procedures with full explanation and dates of limitations on a separate sheet. <input type="checkbox"/> Yes <input type="checkbox"/> No	

ACTIONS, LIMITS, SANCTIONS *If your answer is "yes" to any of these questions, please provide full details on a separate sheet.*

Have any of the following been, or are any currently in the process of being, investigated, denied, revoked, suspended, refused, limited, placed on probation or placed under other disciplinary action?			
(a) Medical license in any state	<input type="checkbox"/> Yes <input type="checkbox"/> No	(g) Other institutional affiliation or status	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Other professional registration/license	<input type="checkbox"/> Yes <input type="checkbox"/> No	(h) Professional society membership or fellowship/board	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) DEA registration	<input type="checkbox"/> Yes <input type="checkbox"/> No	(i) Professional office	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Academic appointment	<input type="checkbox"/> Yes <input type="checkbox"/> No	(j) Participation in any private, state, or federal health insurance program (e.g., Medicare, Medicaid)	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) Membership and/or employment on any hospital medical staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	(k) Any other type of professional sanction	<input type="checkbox"/> Yes <input type="checkbox"/> No
(f) Clinical privileges/other rights on any medical staff	<input type="checkbox"/> Yes <input type="checkbox"/> No		

DISCIPLINARY ACTIONS:

Have you ever been convicted of a misdemeanor or felony or are you currently under indictment or charged with any alleged criminal activities? If so, please provide details:

I affirm that all information given on this page is true and accurate.

Initials _____ Date _____

DISCIPLINARY ACTIONS <i>If your answer is "yes" to any of these questions, please provide full details on a separate sheet.... continued</i>					
Have you ever been the object of an administrative, civil, or criminal complaint or investigation regarding sexual misconduct?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been placed on probation or disciplined by any training program?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever voluntarily surrendered medical license, staff privileges, DEA registration or consented to a limitation of the same pending a review or investigation?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any other issues that should be disclosed that may have an adverse impact on your ability to deliver effective medical services?					<input type="checkbox"/> Yes <input type="checkbox"/> No
HEALTH STATUS <i>If your answer is "yes" to any of these questions, please provide full details on a separate sheet</i>					
Do you currently have any chemical substance abuse dependency?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any reasons that would prevent you from being able to perform competently the job-related functions of a locum tenens physician?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any reasons that would prevent you from being able to travel and promptly assume locum tenens physician responsibilities in unfamiliar facilities?					<input type="checkbox"/> Yes <input type="checkbox"/> No
PREMEDICAL EDUCATION					
College or University		Degree		Honors	
City		State / Province		Date of graduation (mm/yyyy)	
MEDICAL EDUCATION					
Medical School				Phone	
Address		City	State / Province	ZIP Code	Country
Degree awarded		Attended from (mm/yyyy)	Attended to (mm/yyyy)	Date of graduation (mm/yyyy)	
US/Canadian Medical School: If Medical School is greater or less than 4 years, please explain.					
FIFTH PATHWAY EDUCATION <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete this section.)					
Institution				Phone	
Address		City	State / Province	ZIP Code	Country
Specialty	Program completed <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, please explain on separate sheet)	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Date of completion (mm/yyyy)	
OTHER GRADUATE SCHOOL <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete this section.)					
College or University				Phone	
Address		City	State / Province	ZIP Code	Country
Major	Degree Awarded	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Date of graduation (mm/yyyy)	
INTERNSHIP					
Institution				Phone	
Address		City	State / Province	ZIP Code	Country
Type/Specialty	Program completed? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, please explain on separate sheet)	Program Chair	Attended from (mm/yyyy)	Attended to (mm/yyyy)	
RESIDENCY(IES) <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete this section.)					
Institution				Phone	
Address		City	State / Province	ZIP Code	Country
Type/Specialty	Program completed? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, please explain on separate sheet)	Program Chair	Attended from (mm/yyyy)	Attended to (mm/yyyy)	
FELLOWSHIP OR PRECEPTORSHIP <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete this section.)					
Institution				Phone	
Address		City	State / Province	ZIP Code	Country
Type/Specialty	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Program completed? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, please explain on separate sheet)	Program Chair	

I affirm that all information given on this page is true and accurate.

Initials _____ Date _____

BOARD CERTIFICATIONS						
Name of specialty board	Certified?	Date (mm/yyyy)	Recertified?	Date (mm/yyyy)		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			
If not board certified, have you been accepted to take a specialty examination? <input type="checkbox"/> Yes <input type="checkbox"/> No Date scheduled: _____			If not board certified, how many times have you taken a specialty board examination and failed to pass? _____			
WORK HISTORY <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete this section.)						
<small>List all employment affiliations in month/year format since completion of post-graduate education. (Please list hospital affiliations where you have held privileges listed on this Application.) On a separate sheet, please explain any gaps in your work history.</small>						
Name of Practice/Institution		Was this a locum tenens position? <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone		
Address		City	State / Province	ZIP Code		
From date (mm/yyyy)		To date (mm/yyyy)	Position held			
Name of Practice/Institution		Was this a locum tenens position? <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone		
Address		City	State / Province	ZIP Code		
From date (mm/yyyy)		To date (mm/yyyy)	Position held			
Name of Practice/Institution		Was this a locum tenens position? <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone		
Address		City	State / Province	ZIP Code		
From date (mm/yyyy)		To date (mm/yyyy)	Position held			
PROFESSIONAL LICENSES & CONTROLLED SUBSTANCE PERMITS <small>Please list ALL current state medical licenses and state controlled substance permits.</small>						
State	License Number	Date Issued (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	Controlled Substance Permit Number	Date Issued (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)
INACTIVE LICENSES <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete this section.)						
List all States with inactive licenses						
DEA REGISTRATION <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete this section.)						
Registration Number			Date issued (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)		
Registration Number			Date issued (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)		
Registration Number			Date issued (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)		
If you do not currently possess a DEA Registration, please explain here:						
ECFMG / FMGEMS <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete this section.)						
Certificate Number			Date issued			
MILITARY SERVICE <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete this section.)						
Branch		Start Date (mm/yyyy)	End Date (mm/yyyy)			
Status: <input type="checkbox"/> Active <input type="checkbox"/> Honorable Discharge <input type="checkbox"/> Dishonorable Discharge <input type="checkbox"/> Other (please specify)						

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 the reference know Carolina Locum Resources will be calling. If you are just completing a residency or fellowship, please list your program chair as one of the references. If you are unable to provide two same specialty references, an explanation is required

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