Healthcare Connections

Welcome to Healthcare Connections! We thank you for working with us and we will make every effort to provide the best service and experience possible.

Please complete and return the enclosed application along with copies of the documents listed below.

- ☐ **Current Curriculum Vitae**
  Must include work history from receipt of medical degree to the present showing month and year. If there are any gaps, please attach a separate sheet for explanation of disrupted work history.

- ☐ **Medical School Diploma (need English translation)**
- ☐ **Internship Certificate, Residency Certificate(s), and/or Fellowship Certificate(s)**
- ☐ **E.C.F.M.G. Certificate (if applicable)**
- ☐ **All active and inactive State Medical Licenses**
- ☐ **All active and inactive State Controlled Substance Certificates**
- ☐ **Federal DEA Certificate(s)**
- ☐ **Board Certification(s)**
- ☐ **ACLS/BLS/ATLS/PALS**
- ☐ **Current Photograph**
- ☐ **SSN Card / Birth Date**
- ☐ **Drivers' License or Passport**
- ☐ **Proof of citizenship or Visa status (if applicable)**
- ☐ **Current PPD and/or Chest X-Ray**

In addition to the above; please start to gather the additional documentation below as it will be required during the credentialing process:

- ☐ **All current (within the past year) CME's**
- ☐ **Procedure/Activity Logs (last 24 months)**

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

Application for Medical Professional – Locum Tenens

<table>
<tr><th colspan="5">Identifying Information</th></tr>
<tr><td>Last Name:</td><td>First name:</td><td colspan="2">Middle name:</td><td>Suffix:</td></tr>
<tr><td colspan="5">Previous Surname:</td></tr>
<tr><td colspan="5">Degree ☐MD ☐DO ☐MBBS ☐Other (please specify)</td></tr>
<tr><td colspan="3">Social Security Number:</td><td colspan="2">NPI Number:</td></tr>
<tr><td colspan="3">Date of Birth:</td><td colspan="2">Birth Country:</td></tr>
<tr><td colspan="5">Street Address:</td></tr>
<tr><td>City:</td><td>State:</td><td>Province:</td><td>Zip Code:</td><td>Country:</td></tr>
<tr><td colspan="3">Home Phone Number:</td><td colspan="2">Work Phone Number:</td></tr>
<tr><td colspan="5">Cell Phone Number:</td></tr>
<tr><td colspan="3">Email:</td><td colspan="2">Fax:</td></tr>
<tr><td colspan="5">Are you able to work legally in the United States? Yes☐ No☐</td></tr>
<tr><td colspan="5">If yes, please indicate the following: US Citizen Visa or work authorization (You may be asked to provide proof of eligibility to work in the US.) US Citizen ☐ Permanent Resident ☐ Visa ☐</td></tr>
</table>

<table>
<tr><th colspan="4">Medical Education</th></tr>
<tr><td colspan="3">Medical/Osteopathic School:</td><td>Degree:</td></tr>
<tr><td>City:</td><td>State:</td><td>From(mm/yyyy):</td><td>To:</td></tr>
<tr><td colspan="4">Program Completed? (if no, please attach an explanation) Yes☐ No☐</td></tr>
<tr><td colspan="4">If graduated from a Foreign Medical School are you ECFMG Certified? (If no, please attach an explanation)
Yes☐ No☐</td></tr>
</table>

<table>
<tr><th colspan="4">Internship</th></tr>
<tr><td colspan="4">Facility:</td></tr>
<tr><td>City:</td><td>State:</td><td>From(mm/yyyy):</td><td>To:</td></tr>
<tr><td colspan="2">Type/Specialty:</td><td colspan="2">Program Completed? (if no, please attach an explanation) Yes☐ No☐</td></tr>
</table>

<table>
<tr><th colspan="4">Residency</th></tr>
<tr><td colspan="4">Facility:</td></tr>
<tr><td>City:</td><td>State:</td><td>From(mm/yyyy):</td><td>To:</td></tr>
<tr><td colspan="2">Type/Specialty:</td><td colspan="2">Program Completed? (if no, please attach an explanation) Yes☐ No☐</td></tr>
<tr><td colspan="4">Facility:</td></tr>
<tr><td>City:</td><td>State:</td><td>From(mm/yyyy):</td><td>To:</td></tr>
<tr><td colspan="2">Type/Specialty:</td><td colspan="2">Program Completed? (if no, please attach an explanation) Yes☐ No☐</td></tr>
</table>

Fellowship

Facility:			
City:	State:	From(mm/yyyy):	To:
Type/Specialty:	Program Completed? (if no, please attach an explanation) Yes☐ No☐		

Facility:			
City:	State:	From(mm/yyyy):	To:
Type/Specialty:	Program Completed? (if no, please attach an explanation) Yes☐ No☐		

Board Certification

Name of Specialty Board:	Certified: Yes☐ No☐
Date Certified/Recertified:	Number of Attempts:

Name of Specialty Board:	Certified: Yes☐ No☐
Date Certified/Recertified:	Number of Attempts:

Licensure

Please include Active and Inactive licenses and Controlled Substance Registrations

State	License Number	Issued(mm/dd/yyyy)	Expiration Date	Status

DEA Registration

DEA Number:	State:	Issued(mm/dd/yyyy):	Expiration(mm/dd/yyyy):
DEA Number:	State:	Issued(mm/dd/yyyy):	Expiration(mm/dd/yyyy):

Exams & Certifications

	Yes/No:	Expiration(mm/yyyy):
ACLS	Yes☐ No☐	
BLS	Yes☐ No☐	
PALS	Yes☐ No☐	
ATLS	Yes☐ No☐	

Exam Taken:	Date:	Number of Attempts:
USMLE Step 1		
Step2		
Step3		
FLEX		
NATIONAL Boards		

Practice Information			
Please list all Past and Present affiliations, attach a separate sheet if necessary.			
Facility	Location (City, State)	From(mm/yyyy):	To(mm/yyyy):
Have there been any significant changes in you practice in the last 5 years including but not limited to change of Specialty, discontinuing or addition of procedures, etc.? Yes☐ No☐			

Professional References				
Please list four colleagues who have worked with you within the past two years and can attest to your professional skills and competence.				
1. Name:			Specialty:	
Facility:				
Address:		City:	State:	Zip:
Phone:	Fax:	Email:		
2. Name:			Specialty:	
Facility:				
Address:		City:	State:	Zip:
Phone:	Fax:	Email:		
3. Name:			Specialty:	
Facility:				
Address:		City:	State:	Zip:
Phone:	Fax:	Email:		
4. Name:			Specialty:	
Facility:				
Address:		City:	State:	Zip:
Phone:	Fax:	Email:		

Professional Information Questions:	
Please include a detailed explanation for any "Yes" answers below:	
1. Have you ever had a license to practice (including medical, DEA and controlled substance registrations) in any jurisdiction refused, denied, suspended, revoked, restricted, placed on probation, been subject to a reprimand or voluntarily surrendered?	Yes☐ No☐
2. Have you ever been denied by or withdrawn an application from any licensing board?	Yes☐ No☐
3. Have you ever withdrawn an application for clinical privileges?	Yes☐ No☐
4. Have your clinical privileges ever been denied, suspended, revoked, restricted, or placed under any other disciplinary action?	Yes☐ No☐
5. Have you ever been terminated or asked to leave a place of employment or locum tenens assignment?	Yes☐ No☐
6. Have you ever been convicted of a felony or misdemeanor or are you currently charged with any alleged criminal activity?	Yes☐ No☐
7. Have you ever been or are you currently disciplined, sanctioned or under investigation by Medicare or Medicaid?	Yes☐ No☐
Health Status Questions	
Please include a detailed explanation for any "Yes" answers below:	
1. Have you ever or are you currently being treated for alcohol or substance abuse problems?	Yes☐ No☐
2. Is there anything that would prevent you from being able to perform the essential functions of a locum tenens practitioner?	Yes☐ No☐
Professional Liability Questions:	
Please include a detailed explanation for any "Yes" answers below:	
1. Have you ever had professional liability insurance denied or cancelled?	Yes☐ No☐
2. Are you currently, or have you ever been involved directly or indirectly in a claim or suit (including dismissed) due to the rendering or failure to render professional services? If yes, how many?	Yes☐ No☐ #
3. Have any judgments or settlements been made against you in any professional liability cases?	Yes☐ No☐
4. Are you aware of any circumstances which may result in a claim or suit against you?	Yes☐ No☐

Professional Liability History			
Please list all current and previous professional liability insurers for the past 10 years.			
Insurance Carrier:			
Policy Number:	Policy Type (occ or cm)	Start Date(mm/yyyy):	Exp Date(mm/yyyy):
Insurance Carrier:			
Policy Number:	Policy Type (occ or cm)	Start Date(mm/yyyy):	Exp Date(mm/yyyy):
Insurance Carrier:			
Policy Number:	Policy Type (occ or cm)	Start Date(mm/yyyy):	Exp Date(mm/yyyy):
Insurance Carrier:			
Policy Number:	Policy Type (occ or cm)	Start Date(mm/yyyy):	Exp Date(mm/yyyy):

Release of Information and Attestation

The undersigned has requested that Healthcare Connections ("HCC") aid him/her in obtaining medical malpractice insurance coverage and attests and affirms the following:

1. **That the statements set forth in the Application provided to the insurance company are true and correct and agrees that in the event the information changes between the date of the Application and the effective date of the issuance of the insurance coverage, the undersigned will immediately notify HCC in writing of any such change(s). The undersigned acknowledges and understands that the insurance company may withdraw or modify any outstanding quotes, authorizations, or agreements to bind the insurance company for reason of such changes.**

2. **That the execution of the Application does not bind the applicant/undersigned or the insurance company to provide the requested insurance, but it is acknowledged and agreed that the information contained in the Application is the basis of the issuance of the insurance policy should a policy of insurance be issued, and the Application will be attached to and be a part of the insurance policy. All written statements and materials furnished by the undersigned to the insurance company in conjunction with the Application are herein incorporated by reference into the Application and shall be made a part hereof.**

3. **That the undersigned authorizes HCC to make an inquiry of any references, institutions and/or licensing boards in which the undersigned has been enrolled or by whom the undersigned has been employed or has been extended privileges or licensure as to the undersigned's qualifications and claims history, and agrees to execute any and all documents in addition to this Release of Information as may be required to allow HCC to obtain the aforementioned information and authorizes any persons or institutions to forward any and all information regarding the undersigned as requested by HCC, and agrees to hold all such persons and/or institutions harmless from any and all claims or actions that may be brought against them by reason of providing the information to HCC.**

4. **That it is acknowledged by the undersigned that HCC may provide all such information that it receives to the insurance company as may be required by it in its consideration to issue policies of insurance.**

Name (Printed): ____

Signature of Applicant: ____

Date:____________________________________

Healthcare Connections 400 South Woods Mill Road, Suite 115, St. Louis, MO 63017
Phone: (800) 444-8479 Fax: (855) 677-7842 www.healthcareconnections.com