LOCUMCARE

INSTRUCTIONS:
• Please provide the documents in the attached check list.
• We may use application information to complete other forms for you, so it must be comprehensive and accurate.
• Attach any additional pages where necessary.
Please make sure to initial and date the bottom of each page.

Credentialing Application

LOCUM TENENS PROVIDER Degree: ☐ MD ☐ DO ☐ PA-C ☐ ANP ☐ CRNA

IDENTIFYING INFORMATION				
Last Name:	First Name:	Middle Name:	Maiden Name:	Suffix:
Social Security Number:	NPI Number:	*Date of Birth	Birth City, State, Country	
Primary Specialty:	Secondary Specialty:	Other than English, please list all languages you speak:		

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 to work in the US.)

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

CONTACT INFORMATION					
Street Address:		Apt./Unit #	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:	E-mail Address:		

ACTIONS, LIMITS, SANCTIONS (If yes, please provide a written description.)		
Have you ever been named in a malpractice claim(s) (including dismissed actions)? **If yes, please provide a written description from your attorney.**	☐ Yes	☐ No
Has any monetary payment ever been made by you or on your behalf because of alleged medical malpractice?	☐ Yes	☐ No
Are there currently any pending medical malpractice claims or settlements?	☐ Yes	☐ No
Has your professional liability insurance coverage ever been denied, limited, or canceled by the action of any insurance company?	☐ Yes	☐ No
Has your current liability insurance carrier excluded any specific procedures from your insurance coverage?	☐ Yes	☐ No
DISCIPLINARY ACTIONS (If yes, please provide a written description.)		
Have you ever been the subject of any investigation by any private, state, or federal health insurance program?	☐ Yes	☐ No
Other than any traffic violations, have you ever been charged with or convicted of a misdemeanor or felony **or** are you **currently** under indictment **or** charged with any alleged criminal activities?	☐ Yes	☐ No
Have you ever been censured by any committee of a state or county medical association with regard to ethics or fees?	☐ Yes	☐ No
Have you ever been the subject of a licensing board inquiry?	☐ Yes	☐ No
Have you ever withdrawn an application for medical licensure from a state licensing board?	☐ Yes	☐ No
Have you ever withdrawn an application for medical staff membership at any facility?	☐ Yes	☐ No
Have you ever been employed as a physician or provider where your employment was terminated by the employer?	☐ Yes	☐ No
Have you ever been denied HMO, PPO, or other prepaid health plan participation?	☐ Yes	☐ No
Are you currently engaged in any illegal drug activity?	☐ Yes	☐ No
Have you ever been placed on probation or disciplined by any training program?	☐ Yes	☐ No

Initials: _____ Date: _____

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(CONTINUED) DISCIPLINARY ACTIONS (If yes, please provide a written description.)		
Have you ever been the subject of an administrative, civil, or criminal complaint or investigation regarding sexual misconduct?	☐ Yes	☐ 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?	☐ Yes	☐ No
Are there any other issues that should be disclosed that may have an adverse impact on your ability to deliver effective medical services?	☐ Yes	☐ No
HEALTH STATUS (If you answer "YES" to any of these questions, please provide full details on a separate page)		
Do you currently have any chemical substance abuse dependency?	☐ Yes	☐ No
Are there any reasons that would prevent you from being able to competently perform the job-related functions of a locum tenens physician?	☐ Yes	☐ No
Are there any reasons that would prevent you from being able to travel and promptly assume locum tenens physician responsibilities in unfamiliar facilities?	☐ Yes	☐ No

UNDERGRADUATE EDUCATION				
College or University:	Degree Awarded:		Honors:	
From:	To:	Graduation Date:		

MEDICAL EDUCATION				
Medical School:	Degree Awarded:		Phone Number:	
Address:	City:	State:	Zip Code:	Country:
From:	To:	Graduation Date:		

OTHER GRADUATE SCHOOL				
College or University:	Degree Awarded:		Phone Number:	
Address:	City:	State:	Zip Code:	Country:
From:	To:	Graduation Date:		

INTERNSHIP TRAINING				
Institution Name:	Specialty:		Phone Number:	
Address:	City:	State:	Zip Code:	Country:
From:	To:	Program Chair:		
Program Completed? ☐ Yes ☐ No (If "NO", please provide written explain on separate sheet).				

RESIDENCY TRAINING				
Institution Name:	Specialty:		Phone Number:	
Address:	City:	State:	Zip Code:	Country:
From:	To:	Program Chair:		
Program Completed? ☐ Yes ☐ No (If "NO", please provide written explain on separate sheet).				
Institution Name:	Specialty:		Phone Number:	
Address:	City:	State:	Zip Code:	Country:
From:	To:	Program Chair:		
Program Completed? ☐ Yes ☐ No (If "NO", please provide written explain on separate sheet).				

Initials: _____ Date: _____

FELLOWSHIP OR PRECEPTORSHIP TRAINING					
Institution Name:		Specialty:		Phone Number:	
Address:		City:	State:	Zip Code:	Country:
From:	To:	Program Chair:			
Program Completed? ☐ Yes ☐ No (If "NO", please provide written explain on separate sheet).					
Institution Name:		Specialty:		Phone Number:	
Address:		City:	State:	Zip Code:	Country:
From:	To:	Program Chair:			
Program Completed? ☐ Yes ☐ No (If "NO", please provide written explain on separate sheet).					

BOARD CERTIFICATION(S)			
Name of Specialty Board:	Certification Date:	Re-certified?:	Expiration Date:
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

If not board certified, have you been accepted to take a specialty examination? ☐ Yes ☐ No
Date Scheduled:_____

If not board certified, how many times have you taken a specialty board examination and failed to pass? _____

WORK HISTORY

List all employment affiliations in month/year format since completion of post-graduate education. Please explain any gaps in employment greater than 30 days in writing. If you are affiliated with a hospital or organization as part of a job, please list it as well.

Practice / Facility Name:		Locum Tenens?: ☐ Yes ☐ No		Phone Number:	
Address:		City:	State:	Zip Code:	Country:
From:	To:	Position Held:			
Practice / Facility Name:		Locum Tenens?: ☐ Yes ☐ No		Phone Number:	
Address:		City:	State:	Zip Code:	Country:
From:	To:	Position Held:			
Practice / Facility Name:		Locum Tenens?: ☐ Yes ☐ No		Phone Number:	
Address:		City:	State:	Zip Code:	Country:
From:	To:	Position Held:			
Practice / Facility Name:		Locum Tenens?: ☐ Yes ☐ No		Phone Number:	
Address:		City:	State:	Zip Code:	Country:
From:	To:	Position Held:			

Initials: _____ Date: _____

(CONTINUED) WORK HISTORY

List all employment affiliations in month/year format since completion of post-graduate education. Please explain any gaps in employment greater than 30 days in writing. If you are affiliated with a hospital or organization as part of a job, please list it as well.

Practice / Facility Name:	Locum Tenens?: ☐ Yes ☐ No		Phone Number:	
Address:	City:	State:	Zip Code:	Country:
From:	To:	Position Held:		

Practice / Facility Name:	Locum Tenens?: ☐ Yes ☐ No		Phone Number:	
Address:	City:	State:	Zip Code:	Country:
From:	To:	Position Held:		

Practice / Facility Name:	Locum Tenens?: ☐ Yes ☐ No		Phone Number:	
Address:	City:	State:	Zip Code:	Country:
From:	To:	Position Held:		

Practice / Facility Name:	Locum Tenens?: ☐ Yes ☐ No		Phone Number:	
Address:	City:	State:	Zip Code:	Country:
From:	To:	Position Held:		
Practice / Facility Name:	Locum Tenens?: ☐ Yes ☐ No		Phone Number:	
Address:	City:	State:	Zip Code:	Country:
From:	To:	Position Held:		

PROFESSIONAL LICENSES AND CONTROLLED SUBSTANCE PERMITS

Please list ALL current state medical licenses and state controlled substance permits.

Have you ever failed to pass any state board, national board (NMBE or NBOME), FLEX, or USMLE examination? **If "YES", please provide written explanation on a separate sheet.** ☐ Yes ☐ No

State	License Number	Iss. Date	Exp. Date	Controlled Substance Reg. No	Iss. Date	Exp. Date

INACTIVE LICENSE(S)

Initials: ____________________ Date: ____________________

DEA REGISTRATION(S)

Registration Number:	Date Issued:	Date Expired:
Registration Number:	Date Issued:	Date Expired:
Registration Number:	Date Issued:	Date Expired:
Registration Number:	Date Issued:	Date Expired:

ECFMG / FMGEMS ☐ Yes ☐ No

Certificate Number:	Date Issued:

MILITARY SERVICE ☐ Yes ☐ No

Branch:	Start Date:	End Date:

PROFESSIONAL LIABILITY INSURANCE (please list all carriers and policy numbers for the past ten (10) years)

Present Carrier:		Policy Number:		Years With Company:
From:	To:	Coverage Limits:		
Address:	City:	State:	Zip Code:	Country:
Previous Carrier:		Policy Number:		Years With Company:
From:	To:	Coverage Limits:		
Address:	City:	State:	Zip Code:	Country:
Previous Carrier:		Policy Number:		Years With Company:
From:	To:	Coverage Limits:		
Address:	City:	State:	Zip Code:	Country:
Previous Carrier:		Policy Number:		Years With Company:
From:	To:	Coverage Limits:		
Address:	City:	State:	Zip Code:	Country:
Previous Carrier:		Policy Number:		Years With Company:
From:	To:	Coverage Limits:		
Address:	City:	State:	Zip Code:	Country:
Previous Carrier:		Policy Number:		Years With Company:
From:	To:	Coverage Limits:		
Address:	City:	State:	Zip Code:	Country:
Previous Carrier:		Policy Number:		Years With Company:
From:	To:	Coverage Limits:		
Address:	City:	State:	Zip Code:	Country:
Previous Carrier:		Policy Number:		Years With Company:
From:	To:	Coverage Limits:		
Address:	City:	State:	Zip Code:	Country:

Initials: ____________________ Date: ____________________

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REFERENCES (Please provide a minimum of THREE (3) clinical peer references whom you have worked with **within the past 24 months**, TWO (2) of whom are practicing in your same specialty.)

Name: _____ Address: _____

Specialty: _____ City, State, Zip: _____

Phone: _____ E-mail Address: _____

Name: _____ Address: _____

Specialty: _____ City, State, Zip: _____

Phone: _____ E-mail Address: _____

Name: _____ Address: _____

Specialty: _____ City, State, Zip: _____

Phone: _____ E-mail Address: _____

Name: _____ Address: _____

Specialty: _____ City, State, Zip: _____

Phone: _____ E-mail Address: _____

Name: _____ Address: _____

Specialty: _____ City, State, Zip: _____

Phone: _____ E-mail Address: _____

Initials: _____ Date: _____

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Past and Pending Claims Information

Please complete a separate form for each incident reported

Patient Name

first *last*

Age | Gender | Date of incident | Date of claim

Nature of treatment and diagnosis at time of incident

Allegations made against you

Did the patient expire? Yes No

Disability

Name of insurance carrier

Policy number#

Was the case settled? Yes No

Pending Suit dropped Dismissed

Mediation/Arbitration

Amount of settlement

Settled Trial

Name of other doctors and hospitals, if any, involved in the claim or suit

To whom may we refer for further information about the claim: **(if suit - name, address & phone number of defense attorney)**

I hereby authorize release to any insurance company and its agents of information from my insurance carriers, their adjusting firms, and attorneys concerning my past or persent claim matters in which I am involved.

If you are printing this form, please sign on the signature line. To submit this form electronically, you must check the "I Agree" box, or use a digital signature. The Electronic Signatures Act (Public Law No: 106-229) went into effect on October 1, 2000 and gives electronic contracts the same weight as those executed on paper. By checking the "I Agree" button or using a digital signature, you are agreeing with the statements listed in the application you just completed and are placing your Electronic Signature on the Electronic Document.

Signature: _____ ☐ I agree

Print Name: _____ Date: