LOCUMCARE

Please Check Box:
☐ Physician
☐ Advance Practice
☐ CRNA

PERSONAL INFORMATION

Name | Previous/Other Names

Home Address | Cell Phone

City/State/Zip | Home Phone

Specialty | Email Address

Place of Birth | Citizenship | Visa Status

Social Security Number | Date of Birth

NPI# | Medicaid # | Medicare # | Federal Tax ID #

Emergency Contact/Relationship: | Phone:

MEDICAL EDUCATION: *Please list all institutions attended. Use separate sheet if necessary.*

Medical School

Street Address

City/State/Zip | Dates (mm/yy) Attended From | to

Country | Completed Program ☐Yes ☐No

ECFMG # | Date issued:

ADDITIONAL TRAINING: *Please list all institutions attended. Use separate sheet if necessary.*

Internship

Hospital

Street Address

City/State/Zip | Dates (mm/yy) Attended From | to

Country | Completed Program ☐Yes ☐No

Specialty | Program Director

Residency

Hospital

Street Address

City/State/Zip | Dates (mm/yy) Attended From | to

Country | Completed Program ☐Yes ☐No

Specialty | Program Director

Fellowship

Hospital

Street Address

City/State/Zip | Dates (mm/yy) Attended From | to

Country | Completed Program ☐Yes ☐No

Specialty | Program Director

Applicant name: _____

DISCIPLINARY ACTIONS

Have any of the following **ever been** or are any **currently** in the process of being **denied**, **revoked**, **suspended**, **reduced**, **limited**, **placed on probation**, **not renewed**, **surrendered**, **investigated**, **terminated**, **lost**, **withdrawn**, **restricted**, **reprimanded**, **disciplined, stipulated, fined, sanctioned, excluded, discharged,** made subject to a **consent order** or **relinquished**? Your response should include both voluntary and involuntary scenarios. Willful and substantial omissions or misrepresentation may result in denial.

1. Medical License in any state? ☐Yes ☐No	6. Institutional affiliation / status? ☐Yes ☐No
2. DEA Registration (federal or state programs)? ☐Yes ☐No	7. Professional society membership or fellowship / Board certification? ☐Yes ☐No
3. Other Professional Registration / License? ☐Yes ☐No	8. Any professional sanction (e.g. government, administrative agency or other)? ☐Yes ☐No
4. Clinical Privileges? ☐Yes ☐No	9. Participation in any private, federal, or state health insurance program (e.g. Medicare, Medicaid)? ☐Yes ☐No
5. Membership / Rights on any medical staff? ☐Yes ☐No	
10. Are you currently using, or have you ever used or abused, illegal drugs or legal drugs in an illegal manner? ☐Yes ☐No	
11. Have you ever had any physical or mental condition, including substance abuse or dependency, that has impaired or may impair your ability to work safely and according to accepted standards of performance with patients as a practitioner, or has otherwise been deemed to be a violation of the law? ☐Yes ☐No	
12. Is there any reason that you are unable to perform the essential functions of the position for which you are applying safely and according to accepted standards of performance, with or without reasonable accommodation? ☐Yes ☐No	
13.Have any criminal charges (felony or misdemeanor) ever been brought against you (or are currently pending against you) in any jurisdiction? ☐Yes ☐No	
14. Have you ever been arrested for, or charged with, a crime involving children, sexual offenses (including sexual harassment) or moral turpitude? ☐Yes ☐No	
15. Have you ever been convicted, pled guilty or pled nolo contendere, for any criminal offense (excluding traffic infractions with fines of $250 or less)? ☐Yes ☐No	
16. Is there any other issue which should be disclosed that may have an adverse impact on your ability to deliver effective clinical health care services? ☐Yes ☐No	
17. Has any information pertaining to you ever been reported to the National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protections Data Bank (HIPDB)? ☐Yes ☐No	

If any of the above questions is "yes", please provide dates, details and reasons, as specified in each question, as an addendum and attach to the Application.

Applicant name: _____

MALPRACTICE CLAIMS HISTORY

1. Have you ever been denied professional liability insurance or denied renewal of an existing policy?
If the answer to the above question is "YES" please attach a brief explanation. ☐Yes ☐ No

2. Have any malpractice claims, suits, settlements, or arbitration proceedings ever been made against you including any that have been dismissed? ☐Yes ☐ No

3. Are you aware of any claims, suits, or settlements currently pending or of any intent to file a claim or suit? ☐Yes ☐ No

If your answer to any of the above questions is "Yes", please provide the following information on each claim and attach a brief clinical summary of each case.

	Plaintiff Name and Insurance Carrier	Location (County, State)	Status (Pending / Settled / Dismissed / Judgment / On Appeal)	Date of Incident (mm/yy)	Amount of Settlement or Judgment Award (if appropriate)
1					
2					
3					
4					

☐Additional Malpractice Claims or incidents are listed on attached sheet

Please list your current malpractice insurance carrier and the associated information for the last 10 years. If you currently do not carry any malpractice insurance, please list the last malpractice insurance carrier which provided coverage for you. In addition, please list any malpractice insurance carrier who has been associated with any malpractice claim, suit or settlement listed above.

Malpractice Insurance Carrier	Policy Number	Policy Dates From (mm/yy)	Policy Dates To (mm/yy)	Amount of Coverage

MALPRACTICE CLAIMS SUMMARY

Please use separate sheet if required.

AUTHORIZATION, ATTESTATION AND RELEASE

I acknowledge that Locum Care, LLC has been engaged to provide (i) certain credentialing services from time to time on an on-going basis in connection with my candidacy for locum tenens or full-time placement with hospitals, clinics or other healthcare clients (each a "Client") of a placement agency or other third-party working for my benefit, and/or (ii) certain services in the furtherance of one or more applications to state medical boards or other designated bodies ("Boards") to assist me in securing a license to practice medicine in one or more states ("License Applications" and, together with any credentialing applications, the "Applications"). I further acknowledge that any fees or costs payable to such Boards or associated with such Applications, shall be my responsibility unless Locum Care LLC provides advance written notice of its or its Client's intent to pay such fees and costs. I understand that, as part of both the credentialing and licensing processes, Locum Care LLC must collect Information (defined below) from me and from third parties and may share all or part of that Information with other third parties. "Information" includes, but is not limited to, otherwise privileged or confidential information concerning my professional qualifications, credentials, current licensure, education, training, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnoses and treatment, ethics, behavior, or any other matter having a bearing on my qualifications for a license to practice medicine or for credentialing with Locum Care LLC and the Clients (whether it has such a bearing may be presumed by such third parties solely by receipt of a request of Information from an Agent).

I further acknowledge and understand that my cooperation in providing and assisting Locum Care LLC in obtaining my Information and my consent to the release of Information does not guarantee that any state will grant me a license to practice medicine or that a Client will grant me clinical privileges or contract with me as a provider of healthcare services. I understand that my credentialing application is not an application for employment and that acceptance of my application will not in itself result in my employment.

Agreement to Provide Information
I agree to provide, on a timely basis, sufficient and accurate accounts of my Information as deemed necessary or appropriate by Locum Care LLC for the completion, submittal and support of one or more of my Applications.

Authorization of Investigation Concerning Application
I authorize Locum Care LLC and any Client, and their respective employees, affiliated entities and representatives and agents (together and individually the "Agents"), to collect, hold, and investigate both oral and written statements, records, and documents containing my Information, concerning or to be included in any of my Applications. I agree to allow the Agents to inspect and copy all records and documents relating to any Application and to disclose any such Information to a Client, any Board and other appropriate third parties and to share any such Information among themselves in connection with their investigations.

Authorization of Third-Party Sources to Release Information
I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, promptly upon an Agent's request to release Information to the Agent(s). I authorize my current and past professional liability carrier(s) to release to Agents my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide Information based upon this Authorization, Attestation and Release.

Release from Liability
I release from all liability and hold harmless the Agents, any entity responding to a request for Information by an Agent as authorized hereunder and any other third party, and their respective owners, managers, directors, officers, employees, agents and representatives, for their acts performed in good faith and without malice, unless such acts are due to the gross negligence or willful misconduct of such Agent or other third party, in connection with the gathering, holding, use, sharing and interpretation of, and reliance upon, Information. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for credentialing activities.

Attestation
I certify that all Information provided by me in connection with the Applications is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify Locum Care LLC (any Client, if requested) within 10 days of any material changes to the Information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided or authorized to be released to Agents in connection with the Applications.

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

APPLICANT'S SIGNATURE: _____ DATE: _____

Print Name: _____

Locum Care use only:

☐ Locum Tenens ☐ Permanent Placement