



Application

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|---|------------|--------------|--|--|
| LAST NAME - MD / DO | FIRST NAME | MIDDLE NAME | ANY OTHER NAMES BY WHICH YOU HAVE BEEN KNOWN | SOCIAL SECURITY NUMBER -- -- |
| HOME ADDRESS | | CITY | STATE | ZIP CODE |
| EMAIL ADDRESS: | | | | CELL TELEPHONE |
| Would you like to be kept updated with email and text message job alerts? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| EMERGENCY CONTACT | | RELATIONSHIP | TELEPHONE | |
| ARE YOU CURRENTLY AMERICAN BOARD CERTIFIED? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| NAME OF SPECIALTY BOARD | | | DATE OF ORIGINAL CERTIFICATION | |

| PEER REFERENCES WITH WHOM YOU HAVE HAD CLINICAL CONTACT DURING THE PAST 12 MONTHS | | |
|--|-----------------------------------|------------|
| REFERENCES WILL NOT BE CONTACTED UNTIL NEEDED FOR PRESENTATION OR TO BEGIN AN ASSIGNMENT | | |
| 1. Name | Dates worked with in mm/yy format | Phone |
| Email | | Fax Number |
| 2. Name | Dates worked with in mm/yy format | Phone |
| Email | | Fax Number |
| 3. Name | Dates worked with in mm/yy format | Phone |
| Email | | Fax Number |

Checklist

- **Concord Medical Group Application:** Includes Application & Release and Authorization.
- **Current Curriculum Vitae (CV)** – include all activities within last 5 years, including month/year format. Please include all permanent and contract work.
- **Claims Information worksheet** (if applicable)
- **3rd Party Documentation of Malpractice Claims** (if applicable)
- **Supplemental Information work sheet** (if applicable)
- **Specialty Board Certification**
- **ECFMG Certificate** (if applicable)
- **Medical School Diplomas, Internship & Residency Certificates**
- **State Medical License**
- **State Controlled Substance Registration Certification (DPS)**
- **DEA Controlled Substance Certificate**
- **PALS card**
- **ACLS card**
- **ATLS card**

Additional documentation may be requested later pertaining to any questions answered in the affirmative under "professional Liability" and "Background Questions." As well as any additional items that may be needed for specific site credentialing

PROFESSIONAL LIABILITY

IF YOU ANSWER YES TO THE FOLLOWING, PLEASE PROVIDE A FULL EXPLANATION OF EACH CASE ON THE PROVIDED SUPPLEMENTAL INFORMATION WORKSHEET

Have any malpractice claims, suits, settlements or arbitration proceedings **EVER** been made against you or any professional entity in which you are a member? If yes, please put the number on the appropriate line and total below.

Total Pending Cases _____

Total Dismissed/Settled/Closed with No Payment . . . _____

Total Dismissed/Settled/Closed with Payment _____

Total Number _____

*In addition to the Malpractice Claim Data Form for each case/claim/settlement/proceeding, please include ANY and ALL additional documentation available from third parties for cases listed

Yes No

BACKGROUND QUESTIONS

IF YOU ANSWER YES TO QUESTIONS 2-16, PLEASE PROVIDE A FULL EXPLANATION ON A SEPARATE SHEET

1. Is there any reason you would not be authorized to work as an independent contractor in the United States?

Yes No

2. Are you currently abusing alcohol, using any illegal drugs, or failing to take legally prescribed drugs in the manner prescribed?

Yes No

3. Have you abused alcohol, used illegal drugs, or failed to take legally prescribed drugs in the manner prescribed in the past? If yes, what drugs, and how recently have you used these drugs?

Yes No

4. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation? (A "yes" answer will not automatically disqualify you from consideration for placement on Concord Medical Group's Roster of eligible providers. Factors such as when the offense was committed and the seriousness and nature of the offense will be considered.)

Yes No

5. Have you ever been convicted of any violation of a state or federal law relating to controlled substances? (A "yes" answer will not automatically disqualify you from consideration for placement on Concord Medical Group's Roster of eligible providers.)

Yes No

6. Have you ever been denied or surrendered a state or federal controlled substances certificate or state license?

Yes No

7. Have you ever been convicted of a violation of any federal or state narcotic law?

Yes No

8. Have you ever been denied a certificate by, or the privilege of taking an examination before, any state board?

Yes No

9. Have your staff/clinic privileges at any hospital, health care facility, and/or clinic been denied, revoked, suspended, curtailed, limited, placed under conditions restricting your practice, or voluntarily surrendered in lieu of investigation?

Yes No

10. Have you ever resigned from a position in lieu of an investigation, or have you ever been terminated from employment?

Yes No

11. Have you ever been disciplined by any state board for unethical conduct?

Yes No

12. Have you ever been denied provider participation in any state or federal Medicare/Medicaid program?

Yes No

13. Have you ever been terminated, sanctioned, penalized by or had to repay money to any state or federal Medicare/Medicaid program?

Yes No

14. Has your license to practice in your profession in any state been reprimanded, sanctioned, placed on probation, curtailed, suspended, revoked, restricted, denied, formally investigated or voluntarily surrendered in order to avoid disciplinary action/investigation by a state board?

Yes No

15. Have you ever been disciplined by a hospital staff or an internship, residency, fellowship or other professional educational program?

Yes No

16. Is there any other issue which should be disclosed that may have an adverse impact on your ability to deliver effective services?

Yes No

MILITARY SERVICE

Military Service: On a separate sheet of paper please explain the circumstances of any less than honorable discharge received. A less than honorable discharge will not be an automatic bar to placement on Concord Medical Group's Roster of Eligible Providers.

Did you serve in the military?

Yes No

Branch

Date of Service

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 Concord Medical Group will rely on the truthfulness of my statements in evaluating my potential to be placed with Concord Medical Group's clients. I hereby release Concord Medical Group, 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 and performances. I acknowledge that the decision to place me on the roster of eligible providers for placement as a contract provider is solely at the discretion of Concord Medical Group, I further acknowledge that I will not enter into an arrangement to provide temporary or permanent provider services with any individual, group or institution to whom I am referred by Concord Medical Group, except through Concord Medical Group, or with Concord Medical Group's consent for a period of two years. By providing your name, signature, and phone numbers you are consenting to receive phone calls from Concord Medical Group and it's affiliates regarding our services.

Provider's Signature

Date



Immunity and Release

By my signature below, I authorize Concord Medical Group to confirm information contained on any document that I provide to Concord Medical Group, including my curriculum vitae, and to conduct background and reference checks on me regarding any information related to possible placement as an independent contractor. This includes information on my education, licensing, work history, Medicare/Medicaid sanctions, malpractice claims and insurance eligibility. Concord Medical Group may gather the information from various sources including, but not limited to, consumer reporting agencies, hospitals, medical institutions or organizations, personal references, physicians, employers (past and present), business and professional associates (past and present), governmental agencies and instrumentalities (local, state, federal, or foreign), university transcript offices, medical schools, the Office of Inspector General and the Federation of State Medical Boards.

I consent to Concord Medical Group sharing this information with Concord Medical Group clients and affiliates, government or other licensing entities, or professional liability insurers. I understand that, upon my request, Concord Medical Group will disclose to me the nature and substance of the information in accordance with federal law. A request for disclosure of information must be made in writing and directed to Concord Medical Group.

I authorize the above-named entities and individuals to release to state licensing boards, hospitals, and Concord Medical Group any information (written or oral), including medical information, files or records about me in their possession required for evaluation of my qualifications for placement as a locum tenens provider. I hereby release the above-named individuals and entities, including Concord Medical Group and its agents, from liability or damages that may result from the release of information described above.

I make this release for the purpose of allowing Concord Medical Group to assist in my request for a license to practice in my profession and to assist in my efforts to work as an independent contractor for Concord Medical Group's clients.

DATE

PLEASE PRINT NAME CLEARLY

SIGNATURE

3RD PARTY DOCUMENTATION FOR MALPRACTICE CLAIMS

3rd party documents are only needed if you answer "yes" any background questions

For each malpractice claim that was settled/dismissed/closed in or after 1990:

- Complete the "Supplemental Information Worksheet" form below AND
- Provide at least one of the following forms of 3rd party documentation
- Correspondences must be on sender's letterhead and include:
 - The plaintiff's name (or identifying information)
 - Date of incident
 - Allegations

Pending Claims:

- **Legal Counsel Correspondence**

*In addition to above requirements, the letter must contain a statement that the "case is defensible".

Finalized Claims: (In addition to the above requirements, all letters must contain the outcome of the claim and total indemnity paid on your behalf)

- **National Practitioner Data Bank Self-Query** (Claims settled/closed since 1990)

*Customer Service 800-767-6732

*<https://icd.npdb-hipdb.com:663/> - 'self-queries' link

*NPDB report preferably no older than ninety (90) days from the date you sign your application

- **Final Court Order and/or Settlement Agreement**

*The Records Department in the county where the claim was filed can assist you in obtaining the Final Court Order and/or Settlement Agreement.

- **Insurance Company/Legal Counsel Correspondence**

*Claims History/Loss Run

- **Facility/Hospital/Clinic Correspondence**

*The Risk Management and/or Legal Department should be able to assist you in obtaining a letter from the Facility/Hospital/Clinic.

- **United States Government Correspondence**

*If the claim occurred while working at a government facility and you were covered under the Federal Tort Claims Act, the Risk Management and/or Legal Department should be able to assist you in obtaining a letter from the Facility/Hospital/Clinic.

- **Patient Compensation Fund Correspondence**

*If the claim occurred in a state in which you were enrolled in the Comp Fund, contact the Comp Fund to obtain a letter stating how much they paid on your behalf.

Patient Compensation Fund correspondence will not be accepted as sole 3rd party documentation. One of the above must also be obtained.

At times, Concord Medical Group may require additional forms of 3rd party documentation for a single claim in the event that the originally submitted information is insufficient.

