



APPLICATION TO
MEDICAL STAFF
LOCUM TENENS PHYSICIAN

INSTRUCTIONS:

- Attach a current curriculum vita to completed application that covers all periods of time, from medical school to present. Indicate month and year.
- Complete a "Supplemental Claim Form" for every malpractice claim, suit, or incident you have EVER experienced. Please make additional copies of the form as necessary.
- 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.

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. CompHealth 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, attach explanation on a separate sheet. | |
| Has your current liability insurance carrier excluded any specific procedures from your insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list excluded procedures with full explanation and dates of limitations on a separate sheet. | |

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

| | |
|---|---|
| Have you ever been the subject of any investigation by any private, state, or federal health insurance program? <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever been convicted of a misdemeanor or felony or are you currently under indictment or charged with any alleged criminal activities? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever been censured by any committee of a state or county medical association with regard to ethics or fees? <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever been the subject of a licensing board inquiry? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever withdrawn an application for medical licensure from a state licensing board? <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever withdrawn an application for medical staff membership at any facility? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever withdrawn your request for any clinical privileges at any facility? <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever been denied HMO, PPO, or other prepaid health plan participation? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever been employed as a physician or provider where your employment was terminated by the employer? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you currently engaged in any illegal drug activity? <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

Initials _____ Date _____

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| | | | | | |
|---|--|-------------------------|--|------------------------------|--|
| 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) | |
| 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 | |

| BOARD CERTIFICATIONS | | | | | | |
|---|--|--------------------------|---|------------------------------------|------------------------------|------------------------------|
| Name of specialty board | Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No | Date (mm/yyyy) | Recertified? <input type="checkbox"/> Yes <input type="checkbox"/> No | 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.) | | | | | | |
| <i>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.</i> | | | | | | |
| 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 | Country | | |
| 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 | Country | | |
| 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 | Country | | |
| From date (mm/yyyy) | To date (mm/yyyy) | Position held | | | | |
| PROFESSIONAL LICENSES & CONTROLLED SUBSTANCE PERMITS <i>Please list ALL current state medical licenses and state controlled substance permits.</i> | | | | | | |
| 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 LIABILITY INSURANCE <i>List all carriers for the past five years. Attach additional pages if necessary.</i> | | | | |
|--|--------------------|---------------------------------|---------------------------------------|------------------------------|
| Present Carrier | | | Policy Number | |
| Coverage Limits | | | Expiration Date | Years with company |
| Address | City | State / Province | ZIP Code | Country |
| Previous Carrier | | | Policy Number | |
| Coverage Limits | | | Expiration Date | Years with company |
| Address | City | State / Province | ZIP Code | Country |
| HOSPITAL AFFILIATIONS <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete this section.) <i>List all current hospital appointments and any held within the past five years. Please attach an additional page if more space is needed.</i> | | | | |
| Hospital | | Formerly known as | | Phone |
| Address | City | State / Province | ZIP Code | Country |
| Department/Service | | Division chief | | Staff Category |
| Start Date (mm/yyyy) | End Date (mm/yyyy) | | Percent of annual admissions/caseload | |
| Hospital | | Formerly known as | | Phone |
| Address | City | State / Province | ZIP Code | Country |
| Department/Service | | Division chief | | Staff Category |
| Start Date (mm/yyyy) | End Date (mm/yyyy) | | Percent of annual admissions/caseload | |
| Hospital | | Formerly known as | | Phone |
| Address | City | State / Province | ZIP Code | Country |
| Department/Service | | Division chief | | Staff Category |
| Start Date (mm/yyyy) | End Date (mm/yyyy) | | Percent of annual admissions/caseload | |
| Hospital | | Formerly known as | | Phone |
| Address | City | State / Province | ZIP Code | Country |
| Department/Service | | Division chief | | Staff Category |
| Start Date (mm/yyyy) | End Date (mm/yyyy) | | Percent of annual admissions/caseload | |
| LICENSING EXAMINATIONS <i>Please attach copies of your exam scores, if available.</i> | | | | |
| <i>Circle original licensing exam:</i> COMLEX COMVEX FLEX National Board NBOME SPEX State - If State exam, which state? _____ USMLE | | Step 1: First exam attempt date | No. of times taken | Date of completion (mm/yyyy) |
| | | Step 2: First exam attempt date | No. of times taken | Date of completion (mm/yyyy) |
| | | Step 3: First exam attempt date | No. of times taken | Date of completion (mm/yyyy) |
| | | | | |
| List any other licensing exams you have taken: | | | No. of times taken | Date of completion (mm/yyyy) |
| Name | | | | |
| Name | | | No. of times taken | Date of completion (mm/yyyy) |

Application to Medical Staff - Locum Tenens Physician

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 CompHealth 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) | |
| 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) | |

| Last Name | First name | Middle name | Previous Surname | Suffix |
|---|--|-------------|------------------|--------|
| <p>RELEASE & AUTHORIZATION</p> | <p>I hereby affirm that the information I have provided on this application and attachments is true and correct and that it can be relied upon by CHG Companies, Inc. and its affiliates (collectively, "CompHealth") for evaluating my potential as a locum tenens physician.</p> <p>By applying for membership to, or when evaluating retention with CompHealth, I hereby authorize CompHealth, its affiliates and successors, to obtain any information that may be relevant to an evaluation of my professional qualifications, including but not limited to information about disciplinary actions or other confidential or privileged information, and other credentials.</p> <p>I agree to provide and authorize the release by CompHealth to CompHealth clients of the following: a) vaccination records; b) reasonable documentation evidencing that I am in good health and free of communicable diseases; c) the result of and/or a copy of my criminal background check, if any; and d) the result of and/or a copy of my drug screen, if any.</p> <p>I authorize CompHealth to disclose to and receive from current, prior, or potential employers and CompHealth clients making a reasonable inquiry, information relating to my qualifications, ability, and character to practice medicine, including information from the following sources: all medical schools, colleges, universities, transcript offices, medical institutions, or organizations, hospitals, employers, personal references, physicians, attorneys, companies or agencies who may furnish my criminal background history, companies that perform drug screens, medical malpractice carriers or organizations, business and professional associates, all government agencies and instrumentalities, the National Practitioner Data Bank, the Federation of State Medical Boards, the American Medical Association, American Osteopathic Association, American Board of Medical Specialties, DEA, state licensing boards, specialty boards, and any other pertinent source. This is a continuing authorization until such time as I have specifically revoked the same in writing which shall apply to all information received at any time by CompHealth relating to my qualifications, ability, and character to practice medicine.</p> <p>I hereby forever waive and release CompHealth, its officers, employees, agents and third parties which provide or receive information regarding my credentials, including but not limited to the Federation of State Medical Boards and those entities listed above, from any claims, causes of action, damages and expenses, including reasonable attorney's fees arising from or relating to the provision, collection, verification, and dissemination of information about me.</p> <p>Further, I agree to hold CompHealth harmless from any and all claims, causes of action, damages, judgments and expenses, including reasonable attorney's fees, arising from or related to the collection, verification and dissemination of credentialing information provided by me. I understand that this does not contemplate a duty to hold CompHealth harmless from claims, causes of action and damages which may arise as a result of information provided about me from sources other than myself.</p> <p>I understand that I have the burden of providing accurate and adequate information to CompHealth, its affiliates or successors, to demonstrate my qualifications. I understand that any misstatement in this form may constitute grounds for denial of referral to practice opportunities, grounds for civil damages, grounds for reporting the same to the NPDB or state licensing boards or cancellation of contract. If any material changes occur affecting my professional status, it is my obligation to notify CompHealth or the appropriate affiliate or successor as soon as possible. I attest that the information contained in this application is correct and complete.</p> <p>I understand that the decision to refer me to practice opportunities by CompHealth is solely at the discretion of CompHealth.</p> <p>I understand that any information received from references by CompHealth, including but not limited to quality evaluations, is confidential and may not be released to me without the consent of the reference.</p> <p>A copy or facsimile of this document shall have the same effect as the original.</p> <p>This document shall be interpreted according to the laws of the State of Utah.</p> <p>Name _____ Social Security number _____</p> <p>Signature _____ Date _____</p> | | | |