Top Docs, Inc.

1025 Old Roswell Road
Suite 204
Roswell, GA 30076
Phone 678-218-5744 Fax 678-710-7112
Toll Free 866-867-3621
www.topdocs.net

PLEASE COMPLETE THE APPLICATION IN ITS ENTIRETY. IF A QUESTION **DOES NOT APPLY** TO YOU **WRITE N/A**. IF ADDITIONAL SPACE IS REQUIRED IN ANSWERING ANY SECTION OF THE APPLICATION, ATTACH ALL INFORMATION ON A SEPARATE SHEET OF PAPER.

Last Name	First Name	Middle Name	Birth Name
Home Address			Apartment Number
City / State / Zip Code	Telephone Number		Email Address
Date of Birth	Place of Birth (City & State)		
Social Security Number	Citizenship		

Office Address
____

____
Suite #

____
City State Zip Code

Office Telephone Number

Federal I.D. Number

Degree: ☐ M.D. ☐ D.O. ☐ Other

Marital Status ☐ Single ☐ Married ☐ Divorced	Name of Spouse / Domestic Partner

Are you eligible to work in the United States? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Name ____________________________	Telephone Number
Address	Relationship
City State Zip Code	

MILITARY STATUS

Have you ever served in the United States Military? ☐ Yes ☐ No

If yes, what branch?	Type of discharge?

Are you a: Disabled Veteran? Yes________ No____________
Veteran of the Vietnam Era? Yes______ No______
Veteran (other)? _____retired (23 Years)______________________ Please Explain:______________________

Primary Practice Specialty:

Sub Specialties:

Other medical interests in practice (research, forensics, academics, etc.)
____

When are you available to work?

Are you interested in permanent opportunities? Yes No

What type(s) of practice opportunities would you prefer?

☐ In-Patient ☐ Out-Patient ☐ Urgent Care ☐ Hospital ☐ Solo Practice
☐ Multi-Specialty Group ☐ Clinic ☐ Government Facility ☐ Other ______________________________

Do you have any geographic preferences?
_________ ____

____

Would you be willing to license in States that you are not currently licensed, should an interesting opportunity arise?

Yes No

EDUCATION

Pre-Medical

College/University:

Degree:

Honors:

Date of Graduation:

Address:

MEDICAL EDUCATION

Medical School:	Degree:
Address:	

Dates Attended	Date of Graduation:

INTERNSHIP

Hospital / Institution:

Address:

Dates Attended (MM/DD/YY):

Type of Internship:	Program Chairperson:

RESIDENCY

Hospital Institution:

Address: :

Dates Attended (MM/DD/YY):

Type of Residency:	Program Chairperson

CONTINUED EDUCATION

Fellowship(s)

Institution:

Address:

Dates Attended (MM/DD/YY):

Type of Fellowship:	Program Chairperson

Board Certification(s)

Specialty/Board	Certification Date	Re-certification Date

Board Eligibility:

CONTINUING MEDICAL EDUCATION (CME's)

Provide a list of all CME activities for which you have received credits in the past 2 years.

____
____
____

PROFESSIONAL ASSOCIATIONS / MEMBERSHIPS

List all professional associations and / or memberships that you are currently a member of.

____
____
____

WORK HISTORY

List in reverse chronological order, beginning with the most recent employer. All dates from medical school to present must be accounted for. Should you have any gaps in your work history, list all dates and reasons on a separate sheet of paper. Also, if additional space is necessary, please attach on a separate sheet of paper.

Name of Institution:	Telephone Number:
Address:	
Dates Employed (MM/DD/YY):	Position:

Name of Institution:	Telephone Number:
Address:	
Dates Employed (MM/DD/YY):	Position:

Name of Institution:	Telephone Number:
Address:	
Dates Employed (MM/DD/YY):	Position:

Name of Institution:	Telephone Number:
Address:	
Dates Employed (MM/DD/YY):	Position:

Reason for leaving most recent employer:

____

____

____

HOSPITAL AFFILIATIONS

List all hospital affiliations, in reverse chronological order, beginning with the most recent. If additional space is required, include a separate sheet of paper.

Name of Hospital:	Telephone Number:
Address:	
Staff Category:	Dates (MM/DD/YY):

Name of Hospital:	Telephone Number:
Address:	
Staff Category:	Dates (MM/DD/YY):

Name of Hospital:	Telephone Number:
Address:	
Staff Category:	Dates (MM/DD/YY):

Name of Hospital:	Telephone Number:
Address:	
Staff Category:	Dates (MM/DD/YY):

EXAMINATIONS/ LICENSES

Which exam did you take to get your original license? (USMLE, State Boards, Flex, etc.)	
Number of times taken?	Dates of completion?

What other licensing exams have you taken? Please list.			
	Exam	**Number of Times Taken**	**Date of Completion**
1)			
2)			
3)			
4)			

LICENSES

List all current and past medical licenses:			
State	**License Number**	**Issue Date**	**Expiration Date**

(Attach copies of all licenses. Please list any additional licenses on a separate sheet of paper. If a substance control number is required for any of the states listed above, attach copies with the license.)

NPI Number	ACLS	ATLS	BLS	PALS
D.E.A. Registration Number:	Issue Date:		Expiration Date:	

(*********ATTACH A COPY**********)

Professional Liability Insurance	
Insurance Carrier:	Policy Number:
Address:	Telephone Number
Coverage Limits	Expiration Date

Insurance Carrier:	Policy Number:
Address:	Telephone Number
Coverage Limits	Expiration Date

Insurance Carrier:	Policy Number:
Address:	Telephone Number
Coverage Limits	Expiration Date

Insurance Carrier:	Policy Number:
Address:	Telephone Number
Coverage Limits	Expiration Date

LICENSURE AND CLAIMS HISTORY

(**If you answer "Yes" to any question, please provide a detailed explanation on a separate sheet of paper.**)

1.) Have you ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental, administrative agency, hospital or professional association?

☐ Yes ☐ No

2.) Have you ever had any State professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused, or accepted only on special terms or voluntary surrender of same?

☐ Yes ☐ No

3.) Have your hospital privileges and / or professional services ever been denied, revoked, suspended, refused, limited, placed on probation, or placed under and disciplinary action?

☐ Yes ☐ No

4.) Have there been or are there any pending malpractice claims, judgments, suits, settlements, or notices of intent to commence action involving you and / or your medical practice? Please provide a completed "Malpractice Claim Reporting Form" with this application

☐ Yes ☐ No

5.) Have you ever been convicted of an act committed in violation of any law or ordinance other than a traffic violation?

☐ Yes ☐ No

6.) Do you have now or have you ever had any problems with or been treated for drug or alcohol dependency?

☐ Yes ☐ No

7.) Have you ever had any professional liability insurance company cancel, decline, refuse to renew, or accept only on special terms, their malpractice insurance?

☐ Yes ☐ No

HEALTH STATUS

Have you ever had or do you now have any physical or mental condition that would compromise your ability to practice medicine or perform clinical assignments?

☐ Yes ☐ No

PROFESSIONAL REFERENCES

PROVIDE AT LEAST (6) SIX REFERENCES FROM PHYSICIANS WHO HAVE HAD CLINICAL CONTACT WITH, AND ARE CAPABLE OF ASSESSING YOUR PROFESSIONAL SKILLS, **WITHIN THE PAST 12 (TWELVE) MONTHS.**

Reference	Address	Telephone Number

ATTESTATION AND AUTHORIZATION

I **certify** that the information on this application is true and complete to the best of my knowledge. I **authorize TOP DOCS, Inc.** to release information contained in this application to its **Risk Management Department, insurance companies, and medical facility clients.**

I hereby **authorize** the disclosure by **any institution (including but not limited to the Federation of State Medical Boards and State Licensing Boards)** information regarding me, including my **education, medical training and employment, skills, experience, fitness to practice medicine, character, work habits, job performance, certification, licensure, hospital staff or clinical privileges, DEA authorization and medical malpractice claims**. The undersigned releases the above from any claims resulting from the disclosure of such opinions to **TOP DOCS, Inc.**

______________________________ ______________________________

SIGNATURE **DATE**

____

PRINT NAME

<u>AUTHORIZATION AND WARRANTY</u>

I **authorize** the release of all information from **Medical Schools, Colleges, Universities, Medical Institutions, Hospitals, Clinics, Physicians, State Medical Boards, Medical Malpractice Carriers, All Government Agencies, and any other source necessary** to assist with my credentialing process.

I understand that all information will be used to **evaluate my professional qualifications, assist with credentialing at Health Care Facilities, and for use when applying to State Medical Boards for licensure are necessary.**

______________________________ ___________________________

SIGNATURE **DATE**

____

PRINT NAME

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DECLARATION HEALTH

I, ____, hereby declare that, to the best of my knowledge, I do not have a **physical or mental condition that would adversely affect my ability to carry out the clinical privileges**, which I have requested as a Locum Tenens physician.

____________________________   __________________

Signature   Date

CONFIRMATION OF APPLICANT'S DECLARATION

I concur with the Declaration of Health presented by:

_______________________________________.

(Applicant's Name)

Signature ________________________   _______________

Physician   Date

Name ____

Address ____

____

Telephone ____

Fax ____

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HEPATITIS B VACCINE

____

DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis-B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis-B vaccination.

☐ I have already been vaccinated with the Hepatitis-B vaccine (date) _____________, at (where: facility, city, state) _________________ _______________________, and therefore decline Hepatitis-B vaccination at this time. (Attach a copy of your immunization record or physician's statement.

☐ I decline Hepatitis-B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis-B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at that time.

____

Name (Please Print)

______________________________ _______________________

Signature **Date**

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License/Credentials Certification

I hereby certify the following:

My license to provide health care services has neither been revoked within the last 10 years, nor is it currently suspended by any state licensing authority for reasons bearing on professional competence, professional conduct or financial integrity;

I am **NOT** currently excluded, suspended or otherwise barred from participation in the Medicare of Medicaid programs or any other Federal or Federally-assisted program;

I have **NOT** currently surrendered my license while formal disciplinary proceeding involving professional conduct is pending;

And,

I will immediately notify the Recruiter and/or Credentialing Coordinator of Top Docs, Inc. if any of the following situations occur:

- My license lapses for any reason or I fail to renew my license when it expires;
- My license to provide medical or health care services is revoked or suspended by any state licensing authority for reasons bearing on professional competence, professional conduct or financial integrity;
- I am excluded, suspended or otherwise barred from participation in the Medicare or Medicaid programs or any other Federal or Federally-assisted programs; and
- I am asked to surrender my license while formal disciplinary proceeding involving professional conduct is pending.

___________________________ ___________________________________

Date Signature

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