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

APPLICATION

Please complete the application in its entirety. If a question **does not apply** to you, please write **N/A**. If additional space is required in answering any section of the application, use the space on the last page or attach an additional sheet of paper.

PERSONAL INFORMATION

Last Name	First Name	Middle Initial	Birth Name

Home Address	Phone Number

City / State / Zip Code	Email Address

Date of Birth	Place of Birth (City & State)

Social Security Number	Citizenship	Are you eligible to work in the United States? ☐ Yes ☐ No

Office Address	Office Phone Number

Degree: ☐ MD ☐ DO ☐ PA ☐ NP ☐ BSN ☐ RN ☐ LPN ☐ Other:	NPI Number

DEA

Please provide a copy of your DEA certificate(s) if you have any.

DEA Number	Issue Date	Expiration Date	Zip Code Associated with Registration
DEA Number	Issue Date	Expiration Date	Zip Code Associated with Registration

EMERGENCY CONTACT INFORMATION

Name	Relationship
Address	Phone Number

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? Veteran of the Vietnam Era? Veteran (other)?
Retired? Other?

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OCCUPATION/PROFESSION

Primary Practice:
Subspecialties:
Other medical interests in practice (research, forensics, academics, etc.)
When are you available to work?
What type(s) of practice opportunities are you interested in? ☐ Inpatient ☐ Outpatient ☐ Urgent Care ☐ Emergency Dept ☐ Hospital ☐ Specialty Group ☐ Government ☐ Commercial ☐ 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?

COLLEGE EDUCATION

College/University:		Dates Attended
Address:		
Degree(s):	Honors:	Date of Graduation

College/University:		Dates Attended
Address:		
Degree(s):	Honors:	Date of Graduation

College/University:		Dates Attended
Address:		
Degree(s):	Honors:	Date of Graduation

College/University:		Dates Attended
Address:		
Degree(s):	Honors:	Date of Graduation

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INTERNSHIPS / RESIDENCIES / FELLOWSHIPS

Hospital / Institution:	Dates Attended
Address:	
Type of Internship:	Program Chairperson:

Hospital / Institution:	Dates Attended
Address:	
Type of Internship:	Program Chairperson:

Hospital / Institution:	Dates Attended
Address:	
Type of Internship:	Program Chairperson:

Hospital / Institution:	Dates Attended
Address:	
Type of Internship:	Program Chairperson:

CERTIFICATIONS/BOARD CERTIFICATIONS

Specialty/Board	Certification/Recertification Date	Expiration Date
Specialty/Board	Certification/Recertification Date	Expiration Date
Specialty/Board	Certification/Recertification Date	Expiration Date
Specialty/Board	Certification/Recertification Date	Expiration Date

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CONTINUING MEDICAL EDUCATION (CME's)

Are you current with your CME as required by your Certification and Licensing bodies? ☐ Yes ☐ No

(Please attach a CME summary for the past 2 years. You may use a CME summary printed from your Certification body or Professional Association.)

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. Note: you may alternatively attach your CV or Resume if it contains the same information.

Name of Institution:		Telephone Number:
Address:		Position:
Date Employed From:	To:	Reason for Leaving:

Name of Institution:		Telephone Number:
Address:		Position:
Date Employed From:	To:	Reason for Leaving:

Name of Institution:		Telephone Number:
Address:		Position:
Date Employed From:	To:	Reason for Leaving:

Name of Institution:		Telephone Number:
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Name of Institution:	Telephone Number:
Address:	Position:
Date Employed From: To:	Reason for Leaving:

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. Note: you may alternatively attach your CV or Resume if it contains the same information.

Name of Hospital:	Telephone Number:
Address**:**	
Staff Category:	Date From: To:

Name of Hospital:	Telephone Number:
Address**:**	
Staff Category:	Date From: To:

Name of Hospital:	Telephone Number:
Address**:**	
Staff Category:	Date From: To:

Name of Hospital:	Telephone Number:
Address**:**	
Staff Category:	Date From: To:

EXAMINATIONS

Record examinations such as USMLE, NBOME, FLEX, PANCE, ANC, AANP.

Exam	Number of Times Taken	Date of Passed
1		
2		
3		
4		

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STATE LICENSES

Please list all current and past medical licenses and provide copies of the license. Additional licenses can be listed 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.)

State	License Number	Issue Date	Expiration Date

RESUSCITATION TRAINING

	BLS	ACLS	PALS	ATLS	NRP
Expiration Date					
Granting Organization (e.g. American Heart, Red Cross, etc.)					

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

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PROFESSIONAL REFERENCES

Provide at least (4) four references from physicians who have had clinical contact with, and are capable of assessing your professional skills, **within the past 12 (twelve) months.**

Name	Address	Email	Phone

ADDITIONAL INFORMATION

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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;
- I am asked to surrender my license while formal disciplinary proceeding involving professional conduct is pending; and
- I have been removed from clinical practice and/or clinical privileges have been suspended.

_____ _____

Signature Date

_____

Printed Name

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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 Federal, State, National Certification Organizations, and Professional Associations)** 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**

_____

PRINTED NAME

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AUTHORIZATION AND WARRANTY

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**

_____

PRINTED 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 duties**, which I have requested as a _____.

_____ _____
Signature Date

CONFIRMATION OF APPLICANT'S DECLARATION

I concur with the Declaration of Health presented by:

_____.
(Applicant's Name)

Signature: _____ Date: _____

Printed Name: _____

Address:

Phone:

Email:

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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.

_____ _____

SIGNATURE **DATE**

_____

PRINTED NAME