

# ■ ■ MEDICAL PROVIDERS, INC.

Dear Provider:

Thank you for your interest in working with Medical Providers, Inc. Please complete and return the enclosed application packet along with legible copies of the documents listed below.

- Current Curriculum Vitae**
- Medical School Diploma**
- Internship Certificate**
- Residency Certificate**
- Fellowship Certificate** (if applicable)
- Board Certification**
- Active medical licenses**
- DEA Certificate**
- State Controlled Substance Registration Certificate**
- ACLS / BCLS / ATLS** (please include front & back copies of all applicable certifications)
- Copies of CME for the last two years** (n/a if residency training just completed)
- Documentation of negative PPD within the last year (or a negative chest x-ray if positive PPD)**
- Documentation of vaccination for Hepatitis B**
- Documentation vaccination for measles, mumps, rubella (or a rubella titer of 1.8 or greater)**
- Documentation of vaccination for varicella (or positive serology)**

Please do not leave any areas or questions blank on the application. If the question does not apply, indicate this by marking "N/A". Once you have completed the application, send it along with your supporting documents to:

**Medical Providers, Inc.  
313 Berkley Place  
Birmingham AL 35209-2323**

We will review your application and be back in touch with you promptly. If you have any questions about the application process or Medical Providers, Inc., in general, please don't hesitate to ask!

We appreciate this opportunity to work with you!

**1. GENERAL INFORMATION**

Last Name:                      First Name:                      Middle:                      Degree: (MD,DO,etc)

Specialty:                      Date of Birth:                      Social Security Number:                      Gender:     M     F

Home Address:

City:    State:    Zip Code:

Home Phone:    Fax:

Pager:    Cell Phone:

Email:

Mailing Address: (if different)

City:    State:    Zip Code:

Address (Office):

City:    State:    Zip Code:

Are you authorized to work in the United States?     Yes     No                      Languages spoken fluently:

Emergency Contact:    Phone:

Do you wish to contract with Medical Providers, Inc. as a corporate entity?     Yes     No

If yes, name of entity?    Federal Tax ID #:

Name of Current Employer or Group:

Current Practice Type:

- |  |                                       |  |  |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Resident/Fellow | <input type="checkbox"/> Private/Solo | <input type="checkbox"/> Group or Partnership  | <input type="checkbox"/> Hospital/HMO Employee |
| <input type="checkbox"/> Retired         | <input type="checkbox"/> Academics    | <input type="checkbox"/> Military / Government | <input type="checkbox"/> Other _____           |

**2. MEDICAL EDUCATION AND TRAINING**

Medical School: Degree:

Address:

City: State: From: month / year to month / year Completed? Y N

**INTERNSHIP**  
Type of Program:

Hospital:

Address:

City: State: From: month / year to month / year Completed? Y N

**RESIDENCY**  
Specialty:

Hospital:

Address:

City: State: From: month / year to month / year Completed? Y N

**FELLOWSHIP**  
Type/Specialty:

Hospital:

Address:

City: State: From: month / year to month / year Completed? Y N

**3. CERTIFICATIONS AND EXAMS**

Please check all exams and certifications that may apply:

9 BCLS    Expiration Date	9 FLEX: Year:	State:
9 ACLS    Expiration Date	9 National Boards: Year:	No:
9 ATLS    Expiration Date	9 USMLE Step 3: Year:	State:
	9 ECFMG: Year:	No:

**Board Certification:**

Certifying Board:	Date:
Subspecialty Board:	Date:
Recertification Date:	Expiration Date:

If not certified, please note present status below :

- Eligible                     
  Scheduled                     
  Eligible, Not Pursuing                     
  Not Eligible

**4. LICENSURE**

Please list all active and inactive State Medical Licenses.

State	License #	Type	Status

Federal DEA # : \_\_\_\_\_ Expiration Date: \_\_\_\_\_

UPIN # : \_\_\_\_\_

**State Controlled Substance Certificates:**

State	Cert #	Type	Status

**5. AFFILIATIONS**

Please list all current and past hospital affiliations below.

Facility:	City:	State:
From:      month / year      to      month / year	Type of Privileges:	
Facility:	City:	State:
From:      month / year      to      month / year	Type of Privileges:	
Facility:	City:	State:
From:      month / year      to      month / year	Type of Privileges:	
Facility:	City:	State:
From:      month / year      to      month / year	Type of Privileges:	

**6. PREVIOUS MOONLIGHTING / LOCUM TENENS / CONTRACT EXPERIENCE**

Please list all locations where you have provided moonlighting, locum tenens, or contract coverage within the last five years. Please list on additional sheet as necessary.

Institution / Practice Name	Contact	City/State	Coverage Dates

**7. UNDERGRADUATE EDUCATION**

School:	Degree:
City:	State:      From: month / year to month / year      Completed?    Y    N

**8. MILITARY SERVICE**

Branch of Service:	Dates of Service:



**11. PROFESSIONAL REFERENCES**

Please list four colleagues who have worked with you in the past five years and can attest to your clinical competence. If possible, these references should be within your specialty.

(1) NAME: \_\_\_\_\_ Specialty: \_\_\_\_\_

Institution: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

(2) NAME: \_\_\_\_\_ Specialty: \_\_\_\_\_

Institution: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

(3) NAME: \_\_\_\_\_ Specialty: \_\_\_\_\_

Institution: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

(4) NAME: \_\_\_\_\_ Specialty: \_\_\_\_\_

Institution: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**12. MISCELLANEOUS QUESTIONNAIRE**

Please explain any "Yes" answers on a separate sheet.

1. Has your license to practice as a physician in any jurisdiction ever been limited, suspended, revoked, voluntarily surrendered, or placed under investigation or probation?

Yes  No

2. Have you ever been denied a medical license by any licensing board, or have you withdrawn an application for medical license for any reason?

Yes  No

3. Have you ever been denied certification by a specialty board or not been allowed to sit for an exam for any reason?

Yes  No

4. Has your narcotics license ever been suspended, revoked, limited or voluntarily surrendered, or has probation ever been invoked?

Yes  No

5. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action by any medical organization or entity?

Yes  No

6. Have you ever failed to satisfactorily complete any portion of any training program or has your contract with any training program not been renewed for what should have been a subsequent year?

Yes  No

7. Are you now, or have you ever been, under sanction or investigation with regard to Medicare and/or Medicaid?

Yes  No

8. Have your privileges at any hospital ever been suspended, diminished, revoked, withdrawn, or placed under any other disciplinary actions or peer review, or have they ever not been renewed for any reason other than your own voluntary decision not to practice there any longer?

Yes  No

9. Have you ever been convicted of a felony?

Yes  No

**13. PROFESSIONAL LIABILITY HISTORY QUESTIONNAIRE**

Present insurance carrier (NA if in training):

Address	City:	State:	Zip:
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Policy #:	Type of Policy:	Occurrence	Claims Made
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Policy Limits:	Expiration Date:
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Prior insurance carrier (NA if in training):

Address	City:	State:	Zip:
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Policy #:	Type of Policy:	Occurrence	Claims Made
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Policy Limits:	Expiration Date:
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1. Have you ever been denied professional liability coverage? If yes, please explain:

Yes     No

2. Has there been any change in your practice/specialty in the last five years?

Yes     No

3. Have judgments, settlements, or claims been made against you in any professional liability cases, or are there any pending against you or any group or other professional entity of which you are a member?

Yes     No

If yes, please indicate the number of previous and/or pending claims: \_\_\_\_\_ years occurred:

Please provide a detailed narrative of each claim on a separate sheet. Include all information as shown below:

Claim Information:

Patient Name:	Age:	Gender:
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Institution of Incident:	Date of Incident:
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Allegation:

Disposition &amp; amount of settlement or judgment, if any:

Insurance Carrier involved:	City/State:
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**14. RELEASE AND AUTHORIZATION**

By signing below, I certify that all information submitted in this application is true and complete. All information is considered material and important. Should Medical Providers, Inc. provide liability coverage for me, I understand that such liability policy is void if it is found that there was any attempt to mislead, defraud or lie about any information contained in this application. Any coverage offered by Medical Providers, Inc. will not include coverage for any act, error, or omission that occurs while not working through Medical Providers, Inc., and will be contingent upon compliance with applicable Federal/State regulations, underwriting criteria, and risk management inspection regulations.

I further acknowledge that, as a condition to my acceptance, a detailed inquiry and investigation of my background, competence and qualifications may be conducted by Medical Providers Inc., or its agents. In consideration of the foregoing, I consent to any such inquiry and investigation, and I expressly release and discharge Medical Providers, Inc. and its agents, from any and all liability which might be incurred as a result of acts performed in connection with such inquiry or investigation.

I authorize Medical Providers, Inc., and its agents to consult with any persons, entities, institutions, medical licensing boards, and other third parties, including, but not limited to, the Federation of State Medical Boards, who can provide information or documents, privileged or confidential, relating to my professional competence, ethics, personal character and professional liability history. This authorization includes the right to inspect or obtain recommendations, reports, records, disclosures, and other information, both written and oral, that may be relevant to such questions. I release from liability any and all individuals or entities providing such information, in good faith and without malice, and specifically consent to the release of such information. I further consent to the release of information obtained to the client hospitals, clinics, and health care providers of Medical Providers, Inc. I understand that Medical Providers, Inc., may introduce me to client healthcare facilities in order to provide medical services through Medical Providers, Inc., and I agree to work in such referred facilities only through Medical Providers, Inc.

A photocopy of this document shall be acceptable proof to anyone receiving it of my full authorization.

Acknowledged and agreed:

Name: *(printed)*

Social Security Number:

Date of Birth:

Signature:

Date:

 **MEDICAL PROVIDERS, INC.**

313 Berkley Place  
Birmingham AL 35209-2323  
Tel: (205) 913- 9951 Fax: (205) 871- 4156  
[www.medicalproviders.org](http://www.medicalproviders.org)