PROVIDER APPLICATION

We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, sexual orientation, or any other legally protected status.

Name in full ____

Current primary professional activity____

Professional address ____

____Phone________________________________

Residence address____

____Phone________________________________

E-mail address____

Date of birth____________________County & State of Birth ______________________________

Sex ________ Citizen of USA YES _____ NO _____ Social Security #______________________

If private corp. your Federal ID No ____

How did you learn about us? ____

EDUCATION

1. Premedical Education:

   College or University ____

   Degree & Dates of Attendance ____

   Address ____

2. Graduate School or Additional Education:

   Institution ____

   Degree & Dates of Attendance ____

   Address____

3. Medical Education:

Medical School ____

Degree & Dates of Attendance ____

Address ____

4. Post Graduate Training Internship (PGYI):

Institution:____________________________ Program type_______________________

Address ____

Program Director: _____________________ Completion Date_____________________

Residency (1):

Institution: ____________________________ Program type _______________________

Address:____

Program Director: _______________________ Completion Date____________________

Residency (2):

Institution: ____________________________ Program type _______________________

Address:____

Program Director: _______________________Completion Date ____________________

Fellowship:

Institution: ____________________________ Program type _______________________

Address ____

Program Director:_______________________ Completed __________________________

If you did not complete any of the programs above, please give details on a separate sheet.

5 Military Experience:

Branch ___________________ Dates ______________ Current status _______________

6. Board Certifications (please attach copies of all certifications):

Certified by American Board of _________________________ Date_________________

Certified by American Board of _________________________ Date_________________

If not certified, are you Board prepared? Yes _____ no _____ Date__________________

have you been recertified ____________ If yes, when____________________________

Other certifications:	Yes	No	Expiration Date		Yes	No	Expiration Date
ACLS Provider	_____	_____	________	PALS Provider	_____	_____	___________
ACLS Instructor	_____	_____	________	PALS Instructor	_____	_____	___________
ATLS Provider	_____	_____	________	Other	_____	_____	___________

ATLS Instructor ____

ECFMG# _______________ (please attach copy of ECFMG Certificate)

7. Licenses and Certificates (please attach copies of all):

Medical License (State)	License #	Expiration Date
1. ______________________	_____________________	_________________________
2. ______________________	_____________________	_________________________
3. ______________________	_____________________	_________________________

DEA # __________________ State _________________ Expiration date ____________

State Cont. Subst. Cert.# _______________State _______________Exp ._____________

8. Practice Preferences:

Hospitals which interest you: a.____________________ b.________________________

c.______________________ d.____________________ e. ________________________

Full-time interest: yes_________ no _________ Part-time: yes ________ no__________

If part-time, how many shifts/month ____

Available to work as of what date: ____

Are you applying for a long term ___________ or interim __________ position with us?

If currently employed, please list why you are leaving present position.

____

____

May we contact your present employer? Yes________________ No ________________

9. Institutional Affiliations (past and present, in chronological order):

Hospitals	Staff status	Dates on Staff
a.______________________	_____________________	_______________________

Address: ____

Hospitals	Staff status	Dates on Staffb.
______________________	_____________________	_______________________

Address: ____

c. ______________________ ________________________ ________________________

Address: ____

10. Other practice experience (please describe): ______________________________

____

____

____

11. Emergency Department Experience:

Hospital	Dates	Pt. Volume	Coverage Single/Double
1.			
2.			
3.			
4.			

Computer systems used:____

Name of Malpractice Coverage:____

12. Medical Specialty Society Affiliations:

1. _______________________________________ 3. ______________________________

2. _______________________________________ 4. ______________________________

13. Professional References (prefer directors in ED's in which you have worked, program directors or faculty of residencies if appropriate, or physicians with whom you have worked closely in the ED)

1. ______________________________________ Phone __________________________

Address: __________________________________E-mail __________________________

2.____Phone __________________________

Address: __________________________________E-mail__________________________

3.____Phone__________________________

Address: __________________________________E-mail__________________________

4. ____Phone __________________________

Address: __________________________________E-mail__________________________

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, PLEASE GIVE FULL DETAILS ON A SEPARATE SHEET:

		Yes	No	Pending
A.	Is your Medical License in any state ever been limited, denied, suspended, or revoked?	[]	[]	[]
B.	Have you ever voluntarily surrendered any license to practice medicine?	[]	[]	[]
C.	Have your privileges at any hospital ever been suspended, diminished, revoked or voluntarily surrendered?	[]	[]	[]
D.	Have you ever been denied membership or renewal thereof or been subject to disciplinary action by any hospital or medical organization?	[]	[]	[]
E.	Have any medical malpractice suits ever been filed against you?	[]	[]	[]
F.	Has any Professional Liability Insurance ever been denied, canceled or renewal refused?	[]	[]	[]
G.	Have you ever been convicted of a felony, pleaded "nolo contendre" or have you ever been placed on probation for any offense other than a traffic violation?	[]	[]	[]
H.	Has your DEA Certificate ever been denied, suspended or revoked?	[]	[]	[]
I.	Have you ever had any administrative sanctions or been suspended from practicing in Title 18 (Medicare) or Title 19 (Medicaid), or do you have any actions against you in this regard?	[]	[]	[]
J.	Have you ever been charged with violating COBRA/OBRA regulations?	[]	[]	[]
K.	Have you ever been diagnosed or treated for alcoholism, narcotics addiction or mental illness?	[]	[]	[]
L.	Have you ever had a complaint or disciplinary action filed against you by any State Board of Medicine or Pharmacy?	[]	[]	[]

Your contractual arrangement with Kalamazoo Emergency Associates will be contingent upon obtaining staff privileges at the hospital(s) where you may desire to work.

I confirm that the information contained in this application is complete and factual. I authorize Kalamazoo Emergency Associates to contact the references listed in this application and to conduct a customary investigation of my professional background and personal history. A photo-static copy of this authorization shall be as valid as the original.

I hereby release from liability all representative of Kalamazoo Emergency Associates for their acts performing in good faith and without malice in connection with evaluation of my application and my credentials and qualifications, and hereby release from any liability and individuals and organizations who provide information to the Hospital, or its Medical Staff, in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I understand that I have the burden of producing adequate information for proper evaluation of my application.

I understand that falsification of any application information could preclude my employment or association with KEA and could be cause for termination if employment has already begun.

_______________________________ _____________________

Signature Date of application

____

Print Name