JH CVO

CREDENTIALS VERIFICATION ORGANIZATION

CRNA
INITIAL CREDENTIALING
APPLICATION

Revised 04/26

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CRNA APPLICATION

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GENERAL INSTRUCTIONS

Jackson CVO must credential all providers prior to placement into any practice location. All information requested in this application is necessary to complete the credentialing process. This information is based on the standards for credentialing established by the National Committee for Quality Assurance (NCQA) and The Joint Commission (JCAHO). ***Failure to provide the specific requested information will result in delay in verification and approval of your credentialing file.***

Prior to completing this application, please read and observe the following:

- Type or print legibly your responses.
- Note that modification to the wording or format of this application or agreement will invalidate it.
- All questions must be answered fully and truthfully. If an answer requires an explanation, please provide it on the appropriate form provided. Make additional copies of any of the attached forms if more than one is needed and provide your name on all attachments.
- Note that month/years are required for the education and work history sections of the application.
- Any gap of time greater than sixty (60) days requires explanation. Please use the enclosed explanation form to provide this information.
- Please do not leave any blanks. If a particular section does not apply to you, write “n/a” in that section.
- Any changes to your responses must be lined through and initialed. Use of any form of correctional fluid or tape is not acceptable.
- Please sign and provide a current date on the attestation and release pages of the application, the provider agreement, and any other forms completed.
- After the application has been completed in its entirety, make a copy of the application to retain in your files or computer for future use. Attach all documentation shown on the next page to your application prior to mailing.

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CRNA INITIAL CREDENTIALING CHECKLIST

- ☐ Completed Credentialing Application
- ☐ Signed and Currently Dated Attestation and Release forms
- ☐ Completed W-9 Federal Tax Form
- ☐ Completed Authorization for Direct Deposit Form
- ☐ Current Curriculum Vitae w/ complete Professional History in chronological order ***(month and year must be included)***
- ☐ Copy of Nursing Diploma; ☐ Copy of Anesthesia Diploma
- ☐ National Practitioner Data Bank Self Query
- ☐ Current CME (list of CME activity for the past two years)
- ☐ Copy of Board Certificate AANA/CRNA; ☐ Copy of Recertification Certificate
- ☐ Copy of All Current Active State Licenses
- ☐ Copy of Federal DEA and State Controlled Substance Registrations or certificate(s)
- ☐ Copy of: ☐ BLS, ☐ ACLS, ☐ ATLS, ☐ PALS, ☐ APLS, ☐ CPR Certificates
- ☐ Certificate or Declarations Page of Professional Liability Insurance Coverage / Malpractice Insurance
- ☐ Third party documentation for all Malpractice/Disciplinary Actions OR completion of Appropriate Explanation Form Attached (if applicable)
- ☐ Permanent Resident Card, Green Card or Visa Status (if applicable) ***All non US citizens must provide copy of green card***
- ☐ Military Discharge Record -Form DD-214 (if applicable)
- ☐ 3 recent (within the past 6 months) Written Letters of Recommendation from providers who have directly observed you the past year. (Please ask them to specify the date they last observed you in practice - month/year)
- ☐ Recent Photograph Signed and Dated in the margin
- ☐ Copy of Drivers License or Passport
- ☐ Copy of Immunization records; ☐ TB skin test; ☐ Rubella test or Rubeolla test
- ☐ Copy of National Provider Identifier (NPI#) documentation and Confirmation Letter
- ☐ Completed Locum Tenens Practice Experience Form (If Applicable)

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Please return all of the above requested documents in the enclosed postage-paid envelope or mail to:

JACKSON CVO
ATTN: CREDENTIALING
2655 NORTHWINDS PKWY, 3RD FLOOR
ALPHARETTA, GA 30009

Photo / Identification Required:

ATTACH CURRENT PHOTO HERE.
INDICATE DATE TAKEN
AND SIGN IN INK ACROSS THE BOTTOM
OF PHOTO.

Note: Photo must be:

1. Original
2. No larger than 3 by 4 inches
3. Taken within one year of application
4. Close-up view of self – not profile
5. Instant Polaroid photographs not acceptable

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CRNA APPLICATION

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Personal Information	Last Name Suffix (Jr. Sr. III) First Name Middle			Degree	Social Security Number
	Home Address				Home Phone Number
	City State Zip code				Cell Phone Number
	Office Address				Office Phone Number
	City State Zip code				Office Fax Number
	Citizenship	Birthplace	Date of Birth		Email address:
	Position Desired: ☐ Locum Tenens; ☐ Permanent		Date Available:		NPI #
Education And Training	Nursing School Name and Address				
	Dates (From mm/yy To mm/yy)		Program Director Name and Phone		
	Anesthesia Training School Name and Address				
	Dates (From mm/yy To mm/yy)		Program Director Name and Phone		
	Additional Training – Facility Name			City	State
	Dates (From mm/yy To mm/yy)		Specialty		
	Additional Training -- Facility Name			City	State
	Dates (From mm/yy To mm/yy)		Specialty		
	Year CRNA Certification Received:			Date of Exam:	
Professional Certification	Certification Board		Date Certified		
Clinical Certification	Certification Board		Date Certified		Recertification Date
	BLS Certification: Yes ☐ No ☐ Expiration Date: _____		ACLS Certification: Yes ☐ No ☐ Expiration Date: _____	Date Certified	Recertification Date
Federal Provider Information	Federal DEA Number:	DEA Expiration Date:	UPIN Number:	Medicare #/State: BC/BS #/State:	Medicaid #/State: Champus/Railroad #:

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CRNA APPLICATION

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Provider Name: _____

LICENSURE

Please enter the information in the table below for all states in which you have held a medical license.

STATE	LICENSE NUMBER	LICENSE STATUS	DATE LICENSE GRANTED (MM/YY)	LICENSE EXPIRATION DATE (MM/DD/YY)	STATE MEDICARE PROVIDER NUMBER	STATE MEDICAID PROVIDER NUMBER	STATE CONTROLLED SUBSTANCE PERMIT NUMBER
		Initial License ☐ ☐ Active ☐ Inactive					
		☐ Active ☐ Inactive					
		☐ Active ☐ Inactive					
		☐ Active ☐ Inactive					
		☐ Active ☐ Inactive					
		☐ Active ☐ Inactive					
		☐ Active ☐ Inactive					
		☐ Active ☐ Inactive					

☐ ***Additional licenses listed on attached sheet***

REFERENCES

*Please list two **physician** references and two professional peer references that can comment upon your **current** (**within the past year**) clinical and professional capabilities.*

Name	Specialty	Phone # Fax #
Address	City State Zip code	Email
Name	Specialty	Phone #
Address	City State Zip code	Fax # Email
Name	Specialty	Phone #
Address	City State Zip code	Fax # Email
Name	Specialty	Phone #
Address	City State Zip code	Fax # Email

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CRNA APPLICATION

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WORK HISTORY

Please list all your practice locations and employment affiliations to cover at least the past ten years of clinical practice. ***Beginning and ending month and year are required for each listing.*** Please provide a separate explanation of work gaps over 60 days in duration. If you desire Jackson CVO not to contact these facilities, please indicate so in the contact box and attach a letter of explanation. You may attach an additional sheet if needed.

From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Contact Name and Title		
Phone		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Contact Name and Title		
Phone		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Contact Name and Title		
Phone		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Contact Name and Title		
Phone		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Contact Name and Title		
Phone		Address	City	State	Zip Code

If there are any gaps in your work history, please provide an explanation:

Personal Health Statement:

Do you have any physical or mental conditions that would compromise your ability to practice or perform appropriate clinical duties? Yes ☐ No ☐

Have you used drugs recreationally, had a problem with, or been treated for, alcoholism, narcotic addiction, or mental illness? Yes ☐ No ☐

Do you have, or have you ever had, a chronic illness or physical condition that impairs your ability to practice your specialty? Yes ☐ No ☐

Have you ever used, or do you now use, a controlled substance? Yes ☐ No ☐

Do you need any special accommodations to carry out your daily responsibilities as a CRNA? Yes ☐ No ☐

If you answered “YES” to any of the above questions, please provide full details on a separate sheet of paper, including a description of any accommodations that could be reasonably made to facilitate your performance of such functions without risk of compromise.

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CRNA APPLICATION

LocumTenens.com

DISCIPLINARY ACTIONS

If your answer to any of the following questions is "Yes", please provide a full explanation on the attached Credentialing Application Explanation Form and include any additional documentation as necessary.

Have any of the following ever been, or are currently in, the process of being: denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? If the answer is "Yes" to any item please provide an explanation as outlined above.

1. CRNA License in any state? ☐ Yes ☐ No	6. Institutional affiliation / status? ☐ Yes ☐ No
2. DEA Registration (federal or state programs)? ☐ Yes ☐ No	7. Professional society membership or fellowship / Board certification? ☐ Yes ☐ No
3. Other Professional Registration / License? ☐ Yes ☐ No	8. Any professional sanction (e.g. government, administrative agency or other)? ☐ Yes ☐ No
4. Clinical Privileges? ☐ Yes ☐ No	9. Participation in any private, federal, or state health insurance program (e.g. Medicare, Medicaid)? ☐ Yes ☐ No
5. Membership / Rights on any medical staff? ☐ Yes ☐ No	10. Professional Liability insurance coverage? ☐ Yes ☐ No

11. Do you currently have any physical or mental condition including current alcohol or drug dependency that may affect your ability to practice or exercise the privileges typically associated with the specialty and position for which you are applying? ☐ Yes ☐ No

12. Are you currently using illegal drugs, or legal drugs in an illegal manner; or, are you engaged in any illegal drug activity? ☐ Yes ☐ No

13. Is there any reason that you are unable to perform the essential functions of the position for which you are applying safely and according to accepted standards of performance with or without reasonable accommodation? If yes, explain on the attached form ☐ Yes ☐ No

14. Have you ever been convicted of or entered a plea for any criminal offense (excluding parking tickets), or are you currently under indictment for any alleged criminal activities? ☐ Yes ☐ No

15. Are any criminal charges currently pending against you; or, have you ever been arrested or charged with a crime involving children? ☐ Yes ☐ No

16 Have you ever been denied HMO, PPO, or any other pre-paid health plan participation? ☐ Yes ☐ No

17. Have you ever been arrested for, or charged with, a sexual offense; or have you ever been the object of an administrative, civil, or criminal complaint or investigation regarding sexual misconduct? ☐ Yes ☐ No

18. Have you ever been arrested for, or charged with, a crime involving moral turpitude? ☐ Yes ☐ No

19. Have you ever been the subject of any investigation by any private, state, or federal health insurance program or any other government agency? ☐ Yes ☐ No

20. Have you ever been censored by any committee of a state or county medical association with regard to ethics or fees? ☐ Yes ☐ No

21. Have you ever been employed as a CRNA or provider where your employment was terminated by the employer? ☐ Yes ☐ No

22. Have you ever withdrawn your request for clinical privileges at any facility; or have you ever withdrawn an application for medical staff membership at any facility? ☐ Yes ☐ No

23. Have you ever been the subject of a licensing board inquiry? ☐ Yes ☐ No

24.Have you ever been placed on probation in any training program, or failed to satisfactorily complete any training program or part thereof? ☐ Yes ☐ No

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MALPRACTICE CLAIMS HISTORY

1. Have you ever been denied professional liability insurance or denied renewal of an existing policy?
If the answer to the above question is "YES" please attach a brief explanation.

☐ Yes ☐ No

2. Have any malpractice claims, suits, settlements, or arbitration proceedings been made against you?

☐ Yes ☐ No

3. Are you aware of any claims, suits, or settlements currently pending or of any intent to file a claim or suit?

☐ Yes ☐ No

If your answer to either of the above questions is "Yes" please provide the following information on each claim and provide a brief clinical summary of each case on the attached Professional Liability Claims Information Form..

	Plaintiff Name and Insurance Carrier	Location (County, State)	Status (Dismissed / Settled / Judgment / Pending)	Date of Incident (mm/yy)	Amount of Award or Settlement (if appropriate)
# 1					Summary Included ☐
# 2					Summary Included ☐
# 3					Summary Included ☐
# 4					Summary Included ☐

☐ Additional Malpractice Claims or incidents are listed on attached sheet

Please list your current malpractice insurance carrier and the associated information. If you currently do not carry any malpractice insurance, please list the last malpractice insurance carrier which provided coverage for you. In addition, please list any malpractice insurance carrier who has been associated with any malpractice claim, suit or settlement listed below.

Malpractice Insurance Carrier	Policy Number	Policy Dates From (mm/yy)	Policy Dates To (mm/yy)	Amount of Coverage

Military Service:

Branch	Rank
Dates of Service	
Are you currently in the Military Reserves?	Discharge Status

CURRENT CONTINUING MEDICAL EDUCATION FORM

Please list CME activity within the last 3 years. we require at least (1) one CME. This form can be used in lieu of sending copies of your CME certificate(s). Please make as many copies of this page as needed.

Program Title	Date	Sponsoring Organization	# of CME's

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PROFESSIONAL LIABILITY CLAIMS INFORMATION FORM

The following information is necessary to complete the credentialing verification process and will be kept confidential.
Please print or type answers to the following for any malpractice claims reported to your malpractice insurance carrier, opened, closed, settled or paid. For initial credentialing, please complete a separate form for each claim; For recredentialing, just complete separate forms for the past two (2) years. One case per sheet only (please photocopy first if additional sheets are needed)

PROVIDER'S NAME (required):_____

1. Name of Patient Involved: _____ Age: _____
   Month and Year of Occurrence: ____/_____ Month and Year of Lawsuit: ____/_____
   Event Precipitating Claim:_____ Insurance Carrier at Time: _____

2. What is/was your status: ☐ Primary Defendant ☐ Co-defendant ☐ Other
   Please list other Defendants: _____

What was the patient's outcome? _____

How were you alleged to have caused harm or injury to this patient? _____

Please provide specifics in reference to the adverse event: _____

What is/was your role in this event? _____

Current Status***: (please check one)***

☐ Still pending: as of (date) ___/___/_____

Who is handling the defense of the case? _____

☐ Trial date set, awaiting trial? ☐ Yes ☐ No Trial Date: ____/___/_____

☐ Settled out of court? ☐ Yes ☐ No Date: ____/___/_____ Amount of Total Settlement: $ _____

Amount Paid on Your Behalf: $ _____

☐ Dismissed: Date: ___/___/_____

☐ Defense Verdict: Date: ___/___/_____

☐ Plaintiff Verdict: Date: ___/___/_____

☐ Judgment Amount: $ _____ Date: ___/___/_____ Amount of Total Judgment: $ _____

This professional Liability Claims Information Form is required on all claims/lawsuits. Clinical details are required for all suits, regardless of status or settlement amount.

I certify that the information contained in this form is correct and complete to the best of my knowledge.

Applicant's Signature: _____ **Date:** _____

Print Name: _____

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CRNA APPLICATION

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CREDENTIALING APPLICATION EXPLANATION FORM

Please make as many copies of this page as needed to fully respond to each question. Provide your name on each page if additional sheets are used.

Identify the Section of the application that you are providing an explanation for.

Provider Name: _____

SECTION:	COMMENTS:

Applicant's Signature: _____ Date: _____

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ATTESTATION AND SIGNATURE

DO YOU HAVE CURRENT PROFESSIONAL LIABILITY INSURANCE?		YES ☐		NO ☐		POLICY #	
COMPANY			COVERAGE LIMITS				

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

1. HAS YOUR LICENSE TO PRACTICE MEDICINE IN ANY JURISDICTION EVER BEEN SURRENDERED, LIMITED, SUSPENDED TO REVOKED?	YES	☐	NO	☐
2. HAVE YOU EVER BEEN REFUSED MEMBERSHIP ON A HOSPITAL MEDICAL STAFF?	YES	☐	NO	☐
3. HAS YOUR REQUEST FOR ANY SPECIFIC CLINICAL PRIVILEGE EVER BEEN DENIED OR GRANTED WITH STATE LIMITATIONS?	YES	☐	NO	☐
4. HAVE YOUR PRIVILEGES AT ANY HOSPITAL EVER BEEN SUSPENDED, DIMINISHED, REVOKED OR NOT RENEWED?	YES	☐	NO	☐
5. HAVE YOU EVER SURRENDERED A NARCOTICS REGISTRATION OR HAS ONE EVER BEEN LIMITED, SUSPENDED, OR REVOKED?	YES	☐	NO	☐
6. HAVE YOU EVER BEEN DENIED MEMBERSHIP OR RENEWAL THEREOF, OR BEEN SUBJECT TO DISCIPLINARY ACTION IN ANY MEDICATION ORGANIZATION?	YES	☐	NO	☐
7. HAVE YOU EVER BEEN SUBJECT TO A MEDICAL MALPRACTICE CLAIM?	YES	☐	NO	☐
8. HAVE YOU EVER RECEIVED TREATMENT FOR ALCOHOLISM, DRUG ABUSE, OR PSYCHIATRIC DISORDERS?	YES	☐	NO	☐
9. HAVE YOU EVER BEEN CONVICTED OF A FELONY?	YES	☐	NO	☐
10. HAVE YOU EVER BEEN DENIED A MEDICAL LICENSE?	YES	☐	NO	☐
11. HAS YOUR MEDICARE OR MEDICAID PARTICIPATION EVER BEEN SUSPENDED OR REVOKED?	YES	☐	NO	☐
12. HAVE YOU EVER VOLUNTARILY SURRENDERED, LIMITED OR SUSPENDED YOUR LICENSE TO PRACTICE MEDICINE IN ANY JURISDICTION, UNDER THREAT OF INVESTIGATION, ORDER OF CONSENT INVOKED BY ANY JURISDICTION, OR AS A SETTLEMENT TO AN INVESTIGATION BY A JURISDICTION IN LIEU OF THREATENED MANDATED REVOCATION OR SUSPENSION?	YES	☐	NO	☐
13. HAVE YOU EVER VOLUNTARILY SURRENDERED, LIMITED OR SUSPENDED YOUR PRIVILEGES AT ANY HOSPITAL UNDER THREAT OF INVESTIGATION, ORDER OF CONSENT INVOKED BY ANY HOSPITAL OR AS A SETTLEMENT TO AN INVESTIGATION BY A HOSPITAL IN LIEU OF THREATENED MANDATED REVOCATION OR SUSPENSION?	YES	☐	NO	☐
14. HAVE YOU EVER VOLUNTARILY SURRENDERED, LIMITED OR SUSPENDED YOUR STATE OR FEDERAL NARCOTICS REGISTRATION UNDER THREAT OF INVESTIGATION, ORDER OF CONSENT INVOKED BY ANY STATE OR THE FEDERAL GOVERNMENT OR AS A SETTLEMENT TO AN INVESTIGATION BY A STATE OR THE FEDERAL GOVERNMENT IN LIEU OF THREATENED MANDATED REVOCATION OR SUSPENSION?	YES	☐	NO	☐
15. HAVE YOU EVER BEEN DENIED, REVOKED, OR HAD CANCELLED YOUR MALPRACTICE INSURANCE?	YES	☐	NO	☐

PLEASE PROVIDE THE NAME AND ADDRESS OF SOMEONE WHO WILL ALWAYS KNOW YOUR FORWARDING ADDRESS.

NAME _____ PHONE _____

ADDRESS _____ CITY/STATE/ZIP _____

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ATTESTATION AND SIGNATURE cont.

I hereby affirm that the information provided by me on this application and all attachments to be true, complete and correct and that Jackson CVO will rely on the truthfulness of my statements in evaluating my potential as an independent contractor CRNA for locum tenens assignments or potential for referral for a permanent position; and, that Jackson CVO may immediately terminate any contract entered into with me should any information contained herein be determined to be false. I hereby acknowledge and agree this information may be disclosed to any professional insurance company, hospital or healthcare facility making a written request thereof. I further acknowledge that (a) the decision to offer me as a candidate is solely at the discretion of Jackson CVO, (b) any information received from references or other agencies by Jackson CVO may not be released to me without the consent of the reference or agency, and (c) I agree that I will not enter into an arrangement to provide temporary or permanent physician services with any individual, group or institution to whom I am referred by Jackson CVO except through Jackson CVO with the written consent of Jackson CVO.
In the event that any of the answers or information I have provided become incorrect or incomplete, I will immediately notify Jackson CVO in writing.

Applicant's Signature: _____ **Date:** _____

Print Name: _____

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RELEASE AND WAIVER

I, _____ , hereby authorize the following individuals and entities to release all information (documented, oral or other) about me in their possession to Jackson CVO or its agents:

1. All hospitals at which I have held staff privileges, whether full or limited, temporary or permanent; and all hospitals at which I have received training.

2. All medical/osteopathic societies, educational institutions, specialty boards, and other medical/osteopathic organizations with which I have been associated.

3. All state or Canadian health care licensure boards, federal health agencies to include the National Practitioner Data Bank, and federal and state drug control agencies.

4. All licensed physicians, nurses or other health care professionals of any state, commonwealth, district, or Canadian province.

5. All agencies from which I currently have or previously have obtained malpractice insurance coverage.

6. All attorneys who have participated in civil or criminal actions in which I was named party that pertain to or directly affect my ability to obtain or retain a state medical license, obtain or retain clinical privileges and/or practice medicine.

I hereby release the above-named individuals and entities from all liability for the release of information to Jackson CVO or its agents.

I further authorize Jackson CVO or any of its duly authorized agents to make any investigations that they deem necessary to secure information concerning me which is relevant to the requirement for the granting of clinical privileges as an independent contractor or for licensure, and I further authorize them to release such information they now or may have in the future concerning me to any federal, state, county or local governmental entity or any hospital or other health care facility upon showing that the release of the information is vital to the health, safety, and welfare of the general public.

I hereby make this release and waiver of rights for the purpose of allowing Jackson CVO or its agents to carry out its duties pursuant to my request for evaluation of my credentials for clinical privileges and/or a license to practice my profession.

Applicant's Signature: _____ **Date:** _____

Print Name: _____

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LOCUM TENENS PRACTICE EXPERIENCE

List professional locum tenens experience in chronological order. Attach a separate sheet if necessary.

1. Facility	Phone	
Address	City, State, Zip	
Contact	Date from	To
2. Facility	Phone	
Address	City, State, Zip	
Contact	Date from	To
3. Facility	Phone	
Address	City, State, Zip	
Contact	Date from	To
4. Facility	Phone	
Address	City, State, Zip	
Contact	Date from	To
5. Facility	Phone	
Address	City, State, Zip	
Contact	Date from	To
6. Facility	Phone	
Address	City, State, Zip	
Contact	Date from	To
7. Facility	Phone	
Address	City, State, Zip	
Contact	Date from	To

List Hospital(s) where you were privileged _____
Address _____ City, State, Zip _____
Administrator _____ Date from _____ To_____

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AUTHORIZATION AGREEMENT FOR ACH CREDITS (DIRECT DEPOSIT)

Individual Name _____ **ID Number (Company Tax ID or SSN)** _____

I (WE) hereby authorize LocumTenens.com herein after called Individual, to initiate credit entries and/or correction entries to our ☐ *Checking* ☐ *Savings account (select one)* indicated below at the depository named below, herein called DEPOSITORY, to credit the same such account. I acknowledge that the origination of the ACH transactions to my account must comply with the provisions of the U.S. law.

DEPOSITORY NAME _____ **BRANCH** _____

CITY _____ **STATE** _____

BANK TRANSIT/ABA NUMBER (aka "routing number") _____ **ACCOUNT NUMBER** _____

This authorization is to remain in full force until the Individual has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Individual and DEPOSITORY reasonable opportunity to act upon it.

NAME(S) _____ **TAX ID NUMBER (or SSN)** _____

SIGNATURE _____ **DATE** _____

SIGNATURE _____ **DATE** _____

Please fax completed copy to 678-352-4351

After we receive your completed form, a prenote will be sent to your bank. Afterwards, we must wait six business days to allow time for your bank to validate your account information and get back to us if problems are encountered. Please keep this time frame in mind when anticipating your first direct deposit. If you have any questions concerning whether or not your check will be paper vs. electronic, please call us to verify.

Funds are deposited to your account the Tuesday following payroll. This Tuesday disbursement allows for bank processing time. Payment information is sent to the bank on Friday, but the bank must have two business days for processing transactions.

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