LocumTenens.com

Allied Professional Initial Credentialing Checklist

The following documents are requested to complete your credentialing application:

Name:_____

Copy Current Curriculum Vitae

Copy of Diploma and training certificates

Copy of Current Board Certificates

Copy of any: BLS, ACLS, ATLS, PALS, APLS, NRP certificates

Copies of **ALL** Current State Medical License(s)

(Wallet card with expiration date and number, if not available, the wall certificate)

Copies of State Controlled Substance Registrations, If Applicable

Copies of Federal DEA Certificates, If Applicable

Recent Photograph Signed and Dated in the margin

Copy of current Driver's License or Passport

Copies of current immunization records and recent test results (i.e. TB, MMR, etc)

NPI Number and Confirmation Letter

Please provide your UPIN, Medicaid, Medicare and Other Provider Numbers that may apply.

CME's for the Past Three Years

Locum Tenens Practice Experience (If Applicable)

Case Logs for last 24 months (If applicable)

Malpractice Claims History Form (If Applicable)

DD-214 (Military Service Discharge)

Copy of Permanent Residence Card or VISA (non-US citizens)

Please note: A response of "see CV" is not acceptable unless you submit a current CV Containing the requested information to include month and year, no gaps.

Attention: _____
(Recruiter)

Attach recent photo here.
Indicate date taken

Note: Photo:

1. Original preferred
2. Current within one year of application
3. Color headshot
4. Email/text to cvo@locumtenens.com

Allied Professional Initial Application

Name: _____

Specialty: _____

Date: _____

Availability: When are you available to work? _____

Where would you prefer to work? _____

How many weeks would you like to work Locum Tenens? _____

How did you become aware of us? _____

LocumTenens.com

Please Type or Print in Black Ink: Please attach your Curriculum Vitae

Name			Specialty
Home Address			Home Phone
City/State/Zip			Work Phone
Date of Birth	Place of Birth		Cell Phone
Social Security Number			E-mail Address
Present Position			Fax Number
UPIN#	NPI#	Medicare #	Citizenship
Medicaid #	Federal Tax ID #		VISA Status
Emergency Contact Name/Relationship:		Phone:	

Graduate School: *Please list all institutions attended. Use separate sheet if necessary.*

Graduate School			Degree
Street Address			
City/State/Zip		Dates (Month/Year) Attended From	to

Additional Training: *Please list all institutions attended. Use separate sheet if necessary.*

Additional Training

Hospital			
Street Address			
City/State/Zip		Dates (Month/Year) Attended From	to
Specialty		Program Director	

Additional Training

Hospital			
Street Address			
City/State/Zip		Dates (Month/Year) Attended From	to
Specialty		Program Director	

Additional Training

Hospital			
Street Address			
City/State/Zip		Dates (Month/Year) Attended From	to
Specialty		Program Director	

Additional Training

Hospital		
Street Address		
City/State/Zip	Dates (Month/Year) Attended From	to
Specialty	Program Director	

Military Experience

Branch/Service	Date of Discharge	Type of Discharge

Practice Experience

List all practice locations at minimum for the past Five (5) years. Provide explanation for gaps over 60 days. .

1. Practice Location	Month/Year from	to
Address	Phone	Fax
City/State/Zip	Contact Person	
2. Practice Location	Month/Year from	to
Address	Phone	Fax
City/State/Zip	Contact Person	
3. Practice Location	Month/Year from	to
Address	Phone	Fax
City/State/Zip	Contact Person	

Hospital Affiliations

List all hospital privileges you have held except for additional programs. Please list all dates. Attach separate sheet if necessary.

1. Hospital Name	Dates from (Month/Year)	to
Hospital Address		
City/State/Zip		
Phone/Fax		
2. Hospital Name	Dates from (Month/Year)	to
Hospital Address		
City/State/Zip		
Phone/Fax		
3. Hospital Name	Dates from (Month/Year)	to
Hospital Address		
City/State/Zip		
Phone/Fax		
4. Hospital Name	Dates from (Month/Year)	to
Hospital Address		
City/State/Zip		

Phone/Fax

Gaps in Work History Explanation

Please provide explanation for gaps over 60 days; attach separate sheet if necessary.

Certification

Board Certified	Yes	No	**Issuing Board**	Date Issued	Date Expired :	Certification Number:
Re-Certification	Yes	No	**Recertified Date:**		Expiration Date	
Board Qualified	Yes	No				

Have you ever taken the	**SBTPE:**	Yes (Date)	No
Have you ever taken the	**NCLEX:**	Yes (Date)	No
State Constructed Examination:		Yes (Date)	No
If no, when are you scheduled to take the examination?		Date of Exam	

ATLS	Yes	No	Expiration Date
ACLS	Yes	No	Expiration Date
BLS	Yes	No	Expiration Date
PALS	Yes	No	Expiration Date

Licensure:

Please list all licenses held, both inactive and active. Use separate sheet if required.

State	Number	Date Issued	Date Expires	Active, Inactive or Pending	Controlled Substance Number
DEA					

Professional Societies: *Please list all memberships.*

References

List the names and addresses of professional references for training programs and/or current associates. One should be a department director or physician of comparable authoritative status. References should be directly familiar with your clinical abilities. Two of these references should have worked with you in the past year, preferably in your specialty.

1. Name			Specialty	
Address			Relationship	
City/State/Zip			Phone	Fax
Email			Cell Phone	
Did referee have direct contact with you?	Yes	No	Date of contact from	to
2. Name			Specialty	
Address			Relationship	
City/State/Zip			Phone	Fax
Email			Cell Phone	
Did referee have direct contact with you?	Yes	No	Date of contact from	to
3. Name			Specialty	
Address			Relationship	
City/State/Zip			Phone	Fax
Email			Cell Phone	
Did referee have direct contact with you?	Yes	No	Date of contact from	to
4. Name			Specialty	
Address			Relationship	
City/State/Zip			Phone	Fax
Email			Cell Phone	
Did referee have direct contact with you?	Yes	No	Date of contact from	to
5. Name			Specialty	
Address			Relationship	
City/State/Zip			Phone	Fax

Email		Cell Phone	
Did referee have direct contact with you? Yes	No	Date of contact from	to

Continuing Medical Education

On a separate sheet, list postgraduate activities attended or for which you have received credit in the past three years. Do not include meetings attended as part of additional training. Include printed name and signature, list program, title, date, organization, number of CMEs.

DISCIPLINARY ACTIONS

If your answer to any of the following questions is "**yes**", please provide details and reasons, as specified in each question, on a separate sheet and attach to the Application.

Have any of the following **ever been**, or **currently are** in the process of being **(voluntarily while under investigation or involuntarily, public or private) denied**, **revoked**, **suspended**, **reduced**, **limited**, **placed on probation**, **not renewed**, **surrendered**, **investigated**, **terminated**, **lost**, **withdrawn**, **restricted**, **reprimanded**, **disciplined, stipulated, fined, excluded or discharged** made subject to a **consent order** or **relinquished**? Willful and substantial omissions or misrepresentation may result in denial.

1. Medical 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. Have you ever had any physical or mental condition including 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	
11. Are you currently using or have you ever used illegal drugs or legal drugs in an illegal manner? Yes No	
12. 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	
13. Have you ever been convicted, pled guilty or pled nolo contendere, for any criminal offense (excluding parking tickets)? Yes No	
14. Are any criminal charges currently pending against you or have ever been brought against you in any jurisdiction? Yes No	

15. Have you ever been arrested for or charged with a crime involving children? Yes No

16. Have you ever been arrested for or charged with a sexual offense including sexual harassment? Yes No

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

18. Is there any other issue which should be disclosed that may have an adverse impact on your ability to deliver effective clinical health care services? Yes No

19. Has any information pertaining to you ever been reported to the National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protections Data Bank (HIPDB)? Yes No

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 ever been made against you including any that have been dismissed? 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 and attach.

	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 for the last 10 years. 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 above.

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

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 are privileged:

1. Facility:	Phone:	
Address:	City/State/Zip:	
Administrator:	Date from	to
2. Facility:	Phone:	
Address:	City/State/Zip:	
Administrator:	Date from	to
3. Facility:	Phone:	
Address:	City/State/Zip:	
Administrator:	Date from	to

Authorization, Attestation and Release

I acknowledge that LocumTenens.com CVO, LLC ("LTCVO") has been engaged to provide (i) certain services in the furtherance of one or more applications to state medical boards or other designated bodies ("Boards") to secure for me a license to practice medicine in one or more states ("License Applications" and, together with any credentialing applications, the "Applications") and (ii) certain credentialing services from time to time on an on-going basis in connection with my candidacy for locum tenens or full-time placement with hospitals, clinics or other healthcare clients (each a "Client") of a placement agency or other third-party working for my benefit. I understand that, as part of both processes, LTCVO must collect Information (defined below) from me and from third parties and share all or part of that Information. "Information" includes, but is not limited to, otherwise privileged or confidential information concerning my professional qualifications, credentials, current licensure, education, training, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnoses and treatment, ethics, behavior, or any other matter having a bearing on my qualifications for a license to practice medicine or for credentialing with LTCVO and the Clients (whether it has such a bearing may be presumed by such third parties solely by receipt of a request of Information from an Agent).

I further acknowledge and understand that my cooperation in providing and assisting LTCVO in obtaining my Information and my consent to the release of Information does not guarantee that any state will grant me a license to practice medicine or that a Client will grant me clinical privileges or contract with me as a provider of healthcare services. I understand that my credentialing application is not an application for employment and that acceptance of my application will not in itself result in my employment.

Agreement to Provide Information
I agree to provide on a timely basis sufficient and accurate accounts of my Information as deemed necessary or appropriate by LTCVO for the completion, submittal and support of one or more of my Applications.

Authorization of Investigation Concerning Application
I authorize LTCVO and any Client, and their respective employees, affiliated entities and representatives and agents (together and individually the "Agents"), to collect, hold, and investigate both oral and written statements, records, and documents containing my Information, concerning or to be included in any of my Applications. I agree to allow the Agents to inspect and copy all records and documents relating to any Application and to disclose any such Information to a Client, any Board and other appropriate third parties and to share any such Information among themselves in connection with their investigations.

Authorization of Third-Party Sources to Release Information
I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, promptly upon an Agent's request to release Information to the Agent(s). I authorize my current and past professional liability carrier(s) to release to Agents my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide Information based upon this Authorization, Attestation and Release.

Release from Liability
I release from all liability and hold harmless the Agents, any entity responding to a request for Information by an Agent as authorized hereunder and any other third party, and their respective owners, managers, directors, officers, employees, agents and representatives, for their acts performed in good faith and without malice, unless such acts are due to the gross negligence or willful misconduct of such Agent or other third party, in connection with the gathering, holding, use, sharing and interpretation of, and reliance upon, Information. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for credentialing activities.

Attestation
I certify that all Information provided by me in connection with the Applications is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify LTCVO (and any Client, if requested) within 10 days of any material changes to the Information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided or authorized to be released to Agents in connection with the Applications.

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

APPLICANT'S SIGNATURE: _____ ***DATE:*** _____

Print Name: _____