LocumTenens.com
KNOW BETTER EXPERIENCE.

INITIAL CREDENTIALING APPLICATION

ALLIED HEALTH

ATTACH RECENT PHOTO HERE

or email to cvo@locumtenens.com

1. Color headshot
2. Current within one year of application

DOCUMENT CHECKLIST:

- ☐ Current Curriculum Vitae (In Month/Year Format)
- ☐ Graduate School Diploma and Training Certificates (If applicable)
- ☐ Current Board Certificates (If applicable)
- ☐ **ALL** Current State Medical License(s)
  (Wallet card with expiration date and number, if not available, the wall certificate)
- ☐ State Controlled Substance Registrations (If applicable)
- ☐ Federal DEA Certificate(s) (If applicable)
- ☐ CME's for the Past Two Years
- ☐ Current BLS, ACLS, ATLS, PALS, APLS, NRP Certificates
- ☐ Current Photograph
- ☐ Color Copy of Current Driver's License or Passport
- ☐ Permanent Residence Card or VISA (non-US citizen)
- ☐ Malpractice Claims History Form (If applicable)
- ☐ Current Immunization Records and Recent Test Results (i.e. TB, MMR, etc.)
- ☐ NPI Number Confirmation Letter
- ☐ Mammo #'s and MQSA Required Documentation (Radiologist – if applicable)
- ☐ Case Logs for last 24 months (If applicable)
- ☐ DD-214 (Military Service Discharge) (If applicable)
- ☐ PDMP Confirmation (If applicable)

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.

PERSONAL INFORMATION

Name | Previous/Other Names

Home Address | Cell Phone

City/State/Zip | Home Phone

Specialty | Email Address

Place of Birth | Citizenship | Visa Status

Social Security Number | Date of Birth

NPI# | Medicaid # | Medicare # | Federal Tax ID #

Emergency Contact/Relationship: | Phone:

GRADUATE EDUCATION: *Please list all institutions attended. Use separate sheet if necessary.*

Graduate School

Street Address

City/State/Zip | Dates (mm/yy) Attended From | to

Degree | Completed Program ☐Yes ☐No

ADDITIONAL TRAINING: *Please list all institutions attended. Use separate sheet if necessary.*

Additional Training

Hospital

Street Address

City/State/Zip | Dates (mm/yy) Attended From | to

Country | Completed Program ☐Yes ☐No

Specialty | Program Director

Additional Training

Hospital

Street Address

City/State/Zip | Dates (mm/yy) Attended From | to

Country | Completed Program ☐Yes ☐No

Specialty | Program Director

Additional Training

Hospital

Street Address

City/State/Zip | Dates (mm/yy) Attended From | to

Country | Completed Program ☐Yes ☐No

Specialty | Program Director

Applicant name: _____

GAPS IN TRAINING

Please provide an explanation for gaps in training over 60 days; You may attach a separate sheet if necessary.

Dates(mm/yy): From to

Dates(mm/yy): From to

Dates(mm/yy): From to

Dates(mm/yy): From to

BOARD CERTIFICATION

Please list any active certifications held. Use separate sheet if required.

Board certified? ☐Yes ☐No Issuing Board Certification #

Date issued: Date Expired:

HOSPITAL AFFILIATIONS

List all hospital privileges you have held in the past 10 years.
Please list all dates. Attach separate sheet if necessary.

1. Hospital Name Dates from (Month/Year) to

Hospital Address

City/State/Zip

Phone/Fax Locums Position? ☐Yes ☐No

2. Hospital Name Dates from (Month/Year) to

Hospital Address

City/State/Zip

Phone/Fax Locums Position? ☐Yes ☐No

3. Hospital Name Dates from (Month/Year) to

Hospital Address

City/State/Zip

Phone/Fax Locums Position? ☐Yes ☐No

4. Hospital Name Dates from (Month/Year) to

Hospital Address

City/State/Zip

Phone/Fax Locums Position? ☐Yes ☐No

5. Hospital Name Dates from (Month/Year) to

Hospital Address

City/State/Zip

Phone/Fax Locums Position? ☐Yes ☐No

Applicant name: _____

PRACTICE EXPERIENCE

List all practice locations at minimum for the past 10 years. Provide explanation for gaps over 60 days. You may attach a separate sheet if necessary.

1. Practice Location Date (mm/yy) from to

Address Phone Fax

City/State/Zip Locums position? ☐Yes ☐No

Contact person: Email

2. Practice Location Date (mm/yy) from to

Address Phone Fax

City/State/Zip Locums position? ☐Yes ☐No

Contact person: Email

3. Practice Location Date (mm/yy) from to

Address Phone Fax

City/State/Zip Locums position? ☐Yes ☐No

Contact person: Email

GAPS IN WORK HISTORY

Please provide an explanation for work gaps over 60 days from within the last 10 years; You may attach a separate sheet if necessary.

Dates(mm/yy): From to

Dates(mm/yy): From to

Dates(mm/yy): From to

Dates(mm/yy): From to

Dates(mm/yy): From to

LIFE SUPPORT CERTIFICATIONS

Please list any active certifications held (e.g. ATLS, ACLS, BLS, PALS). Use separate sheet if required.

Expiration Date:

Expiration Date:

Expiration Date:

CERTIFICATION EXAMS

Please provide certification examinations taken; You may attach a separate sheet if necessary.

Exam 1 # Times Taken Date Passed

Exam 2 # Times Taken Date Passed

Exam 3 # Times Taken Date Passed

Applicant name: _____

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 _____

DEA _____

REFERENCES

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

1. Name _____ Relationship _____

Address _____ Email _____

City/State/Zip _____ Phone _____ Fax _____

Specialty _____ Did referee have direct contact with you? Yes ☐ No ☐ Date of contact from _____ to _____

2. Name _____ Relationship _____

Address _____ Email _____

City/State/Zip _____ Phone _____ Fax _____

Specialty _____ Did referee have direct contact with you? Yes ☐ No ☐ Date of contact from _____ to _____

3. Name _____ Relationship _____

Address _____ Email _____

City/State/Zip _____ Phone _____ Fax _____

Specialty _____ Did referee have direct contact with you? Yes ☐ No ☐ Date of contact from _____ to _____

4. Name _____ Relationship _____

Address _____ Email _____

City/State/Zip _____ Phone _____ Fax _____

Specialty _____ Did referee have direct contact with you? Yes ☐ No ☐ Date of contact from _____ to _____

Applicant name: _____

DISCIPLINARY ACTIONS

Have any of the following **ever been** or are any **currently** in the process of being **denied**, **revoked**, **suspended**, **reduced**, **limited**, **placed on probation**, **not renewed**, **surrendered**, **investigated**, **terminated**, **lost**, **withdrawn**, **restricted**, **reprimanded**, **disciplined, stipulated, fined, excluded, discharged,** made subject to a **consent order** or **relinquished**? Your response should include both voluntary and involuntary scenarios. 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. Are you currently using, or have you ever used, illegal drugs or legal drugs in an illegal manner? ☐Yes ☐ No	
11. Have you ever had any physical or mental condition, including substance abuse or dependency, that has impaired or may impair your ability to work safely and according to accepted standards of performance with patients as a practitioner, or has otherwise been deemed to be a violation of the law? ☐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? ☐Yes ☐ No	
13.Have any criminal charges (felony or misdemeanor) ever been brought against you (or are currently pending against you) in any jurisdiction? ☐Yes ☐No	
14. Have you ever been arrested for, or charged with, a crime involving children, sexual offenses (including sexual harassment) or moral turpitude? ☐Yes ☐No	
15. Have you ever been convicted, pled guilty or pled nolo contendere, for any criminal offense (excluding traffic infractions with fines of $250 or less)? ☐Yes ☐No	
16. 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	
17. 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	

If your answer to any of the above questions is "yes", please provide dates, details and reasons, as specified in each question, as an addendum and attach to the Application.

Applicant name: _____

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 any of the above questions is "Yes", please provide the following information on each claim and attach a brief clinical summary of each case.

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

☐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

MALPRACTICE CLAIMS SUMMARY

Use separate sheet if required.

AUTHORIZATION, ATTESTATION AND RELEASE

I acknowledge that LocumTenens.com CVO, LLC ("LTCVO") has been engaged to provide (i) 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, and/or (ii) certain services in the furtherance of one or more applications to state medical boards or other designated bodies ("Boards") to assist me in securing a license to practice medicine in one or more states ("License Applications" and, together with any credentialing applications, the "Applications"). I further acknowledge that any fees or costs payable to such Boards or associated with such Applications, shall be my responsibility unless LTCVO provides advance written notice of its or its Client's intent to pay such fees and costs. I understand that, as part of both the credentialing and licensing processes, LTCVO must collect Information (defined below) from me and from third parties and may share all or part of that Information with other third parties. "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: _____