

# RECREREDENTIALING APPLICATION

## ALLIED HEALTH

ATTACH RECENT  
PHOTO HERE

or email to  
[cvo@locumtenens.com](mailto: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.  
Please include the above listed documents which have been obtained or updated in the past three (3) years.



Applicant name: \_\_\_\_\_

## PRACTICE EXPERIENCE

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

<b>1. Practice Location</b>	Date (mm/yy)	from	to
Address	Phone		Fax
City/State/Zip	Locums position?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contact person:	Email		
<b>2. Practice Location</b>	Date (mm/yy)	from	to
Address	Phone		Fax
City/State/Zip	Locums position?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contact person:	Email		
<b>3. Practice Location</b>	Date (mm/yy)	from	to
Address	Phone		Fax
City/State/Zip	Locums position?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contact person:	Email		

## HOSPITAL AFFILIATIONS

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

<b>1. Hospital Name</b>	Dates from (Month/Year)	to
Hospital Address		
City/State/Zip		
Phone/Fax	Locums Position?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2. Hospital Name</b>	Dates from (Month/Year)	to
Hospital Address		
City/State/Zip		
Phone/Fax	Locums Position?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3. Hospital Name</b>	Dates from (Month/Year)	to
Hospital Address		
City/State/Zip		
Phone/Fax	Locums Position?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4. Hospital Name</b>	Dates from (Month/Year)	to
Hospital Address		
City/State/Zip		
Phone/Fax	Locums Position?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Applicant name: \_\_\_\_\_

### GAPS IN WORK HISTORY

Please provide an explanation for work gaps over 60 days from within the last three 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 _____

### 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.

<b>1. Name</b>		Relationship				
Address		Email				
City/State/Zip		Phone		Fax		
Specialty	Did referee have direct contact with you?	Yes	No	Date of contact	from	to

<b>2. Name</b>		Relationship				
Address		Email				
City/State/Zip		Phone		Fax		
Specialty	Did referee have direct contact with you?	Yes	No	Date of contact	from	to

<b>3. Name</b>		Relationship				
Address		Email				
City/State/Zip		Phone		Fax		
Specialty	Did referee have direct contact with you?	Yes	No	Date of contact	from	to

<b>4. Name</b>		Relationship				
Address		Email				
City/State/Zip		Phone		Fax		
Specialty	Did referee have direct contact with you?	Yes	No	Date of contact	from	to

## 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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	6. Institutional affiliation / status? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
2. DEA Registration (federal or state programs)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	7. Professional society membership or fellowship / Board certification? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
3. Other Professional Registration / License? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	8. Any professional sanction (e.g. government, administrative agency or other)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
4. Clinical Privileges? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	9. Participation in any private, federal, or state health insurance program (e.g. Medicare, Medicaid)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
5. Membership / Rights on any medical staff? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
10. Are you currently using, or have you ever used, illegal drugs or legal drugs in an illegal manner? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
13. Have any criminal charges (felony or misdemeanor) ever been brought against you (or are currently pending against you) in any jurisdiction? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
14. Have you ever been arrested for, or charged with, a crime involving children, sexual offenses (including sexual harassment) or moral turpitude? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
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)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
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)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	

**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.**



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