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*For Office Use Only*

Date Received: \_\_\_\_\_  
 ID #: \_\_\_\_\_

Email: staff@docswhocare.com • Website: www.docswhocare.com

## PROVIDER APPLICATION

*Please complete application fully and return with a copy of your Curriculum Vitae or Resume.  
 (Please Print)*

Name _____	Prof Designation (MD, DO, PA, etc) _____
Home Address _____	Home _____
City/State/Zip _____	Work _____
Place of Birth _____	Mobile _____
Are you a U.S. citizen: Yes No Gender? M F	Pager _____
Other names you may have used (i.e. maiden, etc.) _____	Fax _____
If not a U.S. citizen, indicate your current visa status _____	E-Mail _____
SSN _____	Date of Birth _____

## PROFESSIONAL EDUCATION

*List all medical schools/institutions attended. Please explain any 30 day or greater gap in your training. (Attach additional sheets if necessary.)*

### Medical Education

School Name \_\_\_\_\_ City/State \_\_\_\_\_  
 Degree \_\_\_\_\_ Dates attended from \_\_\_\_\_ to \_\_\_\_\_

### Post Graduate Education

1. **Hospital/Program** \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_ Dates attended from \_\_\_\_\_ to \_\_\_\_\_  
 Specialty \_\_\_\_\_ Program Director \_\_\_\_\_

2. **Hospital/Program** \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_ Dates attended from \_\_\_\_\_ to \_\_\_\_\_  
 Specialty \_\_\_\_\_ Program Director \_\_\_\_\_

## SPECIALTY CERTIFICATION

*Attach copy of certificate(s). If not applicable to your profession/specialty, complete with n/a.*

Board Certification Name \_\_\_\_\_ Certification Number \_\_\_\_\_  
 Initial Date of Certification \_\_\_\_\_ Expiration Date of Current Certification \_\_\_\_\_  
 List all Recertification Dates 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_ 5) \_\_\_\_\_  
 If not certified, indicate current status and/or date intending to sit for boards \_\_\_\_\_

# PROFESSIONAL LICENSE / CERTIFICATION / REGISTRATION NUMBERS

List all states in which you have held, or currently hold, a license to practice your profession. Please attach copies.

State \_\_\_\_\_ Number \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_ Status \_\_\_\_\_

State \_\_\_\_\_ Number \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_ Status \_\_\_\_\_

State \_\_\_\_\_ Number \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_ Status \_\_\_\_\_

Federal Drug Enforcement Agency (DEA) Number(s) \_\_\_\_\_ Expiration Date \_\_\_\_\_

State Controlled Substance license(s) \_\_\_\_\_ State \_\_\_\_\_ Expiration Date \_\_\_\_\_

Medicare/UPIN # \_\_\_\_\_ National Provider Identifier (NPI ) \_\_\_\_\_

Medicaid Number(s) \_\_\_\_\_ Licensing State(s) \_\_\_\_\_

If you are a graduate of a foreign medical school, are you certified by the Education Council for Foreign Medical Graduates (ECFMG)? **Yes/No** \_\_\_\_\_ (If yes, enclose a copy of your certificate with this application.) ECFMG Number \_\_\_\_\_

## CERTIFICATIONS

Please attach a copy of your current certificate(s).

**ATLS** Yes \_\_\_\_\_ No \_\_\_\_\_ Expiration \_\_\_\_\_ **NRP** Yes \_\_\_\_\_ No \_\_\_\_\_ Expiration \_\_\_\_\_

**ACLS** Yes \_\_\_\_\_ No \_\_\_\_\_ Expiration \_\_\_\_\_ **BLS** Yes \_\_\_\_\_ No \_\_\_\_\_ Expiration \_\_\_\_\_

**PALS** Yes \_\_\_\_\_ No \_\_\_\_\_ Expiration \_\_\_\_\_ **ALSO** Yes \_\_\_\_\_ No \_\_\_\_\_ Expiration \_\_\_\_\_

## EMPLOYMENT HISTORY

Please list current employer and last two employers.

1. **Current** Employer \_\_\_\_\_ Dates from \_\_\_\_\_ to \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Contact Person \_\_\_\_\_

2. **Previous** Employer \_\_\_\_\_ Dates from \_\_\_\_\_ to \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Contact Person \_\_\_\_\_

3. **Previous** Employer \_\_\_\_\_ Dates from \_\_\_\_\_ to \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Contact Person \_\_\_\_\_

## HOSPITAL AFFILIATIONS

Please list all hospitals at which you hold or have held privileges.

Key: 1 Active 2 Temporary 3 Courtesy 4 Provisional 5 Other \_\_\_\_\_

1. **Primary** Hospital \_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Status of Privileges (see key) \_\_\_\_\_ Dates from \_\_\_\_\_ to \_\_\_\_\_

2. **Other** Hospital \_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Status of Privileges (see key) \_\_\_\_\_ Dates from \_\_\_\_\_ to \_\_\_\_\_

3. **Other** Hospital \_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Status of Privileges (see key) \_\_\_\_\_ Dates from \_\_\_\_\_ to \_\_\_\_\_

## PROFESSIONAL LIABILITY INSURANCE

*Please attach a copy of your current certificate(s) or declarations(s) of insurance, including HCSF for Kansas practitioners.*

Carrier Name \_\_\_\_\_ Policy Number \_\_\_\_\_

Dates of Coverage from \_\_\_\_\_ to \_\_\_\_\_

Policy Limits: *Per Occurrence* \$ \_\_\_\_\_ *Aggregate* \$ \_\_\_\_\_

### REFERENCES

*List the names and addresses of professional references from training programs and/or current associates. One should be a department director or a physician of comparable authoritative status. References should be directly familiar with your medical abilities within the last 24 months.*

1. Name \_\_\_\_\_ Specialty \_\_\_\_\_

Hospital/Organization Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

2. Name \_\_\_\_\_ Specialty \_\_\_\_\_

Hospital/Organization Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

3. Name \_\_\_\_\_ Specialty \_\_\_\_\_

Hospital/Organization Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

### PERSONAL HISTORY

*Please include a brief summary of your personal history. This may include special interests, volunteer participation, personal goals, etc.*

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### POSITION DESIRED

*Please indicate the desired type of position and approximate start date.*

\_\_\_\_\_ PRN  
\_\_\_\_\_ Less than One-Year Commitment  
\_\_\_\_\_ One-Year Commitment or Longer  
\_\_\_\_\_ Other \_\_\_\_\_

Preferred Start Date \_\_\_\_\_

## ADDITIONAL INFORMATION

*If the answer to any of the following is "yes," please give details on a separate sheet.*

1. Has your authority to practice in any state been suspended, revoked, voluntarily or involuntarily surrendered, been subject to a consent or stipulation order, not renewed, denied renewal, or has probation ever been invoked? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Have you ever been refused membership on a hospital medical staff? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Have any of your board certifications ever been suspended, revoked, not renewed, denied renewal, or voluntarily or involuntarily surrendered? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Has your request for any specific clinical privilege ever been denied or granted with state limitations? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Have your privileges at any hospital ever been suspended, diminished, or revoked? Yes \_\_\_\_\_ No \_\_\_\_\_
6. Have you ever been named as a defendant in any criminal case? Yes \_\_\_\_\_ No \_\_\_\_\_
7. Has your federal or state controlled substance license ever been suspended, revoked voluntarily, or involuntarily surrendered, restricted, not renewed, denied renewal, or has probation ever been invoked? Yes \_\_\_\_\_ No \_\_\_\_\_
8. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization? Yes \_\_\_\_\_ No \_\_\_\_\_
9. Have you ever been subject to a Professional Liability Claim? Yes \_\_\_\_\_ No \_\_\_\_\_
10. Have you ever received treatment for alcoholism, drug abuse, or psychiatric disorders. Yes \_\_\_\_\_ No \_\_\_\_\_
11. Have you ever been convicted, pled guilty, or pled nolo contendere to any felony, any offence reasonably related to your qualifications, functions, or duties as a medical professional, or any offense an essential element of which is fraud, dishonesty, or an act of violence? Yes \_\_\_\_\_ No \_\_\_\_\_
12. Have you ever been denied a medical license? Yes \_\_\_\_\_ No \_\_\_\_\_
13. Has your Medicare or Medicaid participation ever been suspended or revoked? Yes \_\_\_\_\_ No \_\_\_\_\_
14. 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 \_\_\_\_\_
15. 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 \_\_\_\_\_
16. 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 \_\_\_\_\_
17. Have you ever been denied, revoked, or had canceled your Professional Liability Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_
18. Have you discontinued practice for any reason (other than routine vacation) for one month (30 days) or more? Yes \_\_\_\_\_ No \_\_\_\_\_
19. Within the last five years, have you ever been reprimanded or disciplined in any manner by any state licensing authority or other professional board or peer review committee for conduct related to the use of alcohol or the use of any drug? Yes \_\_\_\_\_ No \_\_\_\_\_
20. Has any information on you ever been reported to the National Practitioner Data Bank? Yes \_\_\_\_\_ No \_\_\_\_\_

**\*\* If the answer to any of the above is "yes," please give details on a separate sheet. \*\***

*Applicant agrees 1) that the information contained herein and the references obtained and verification received in connection with processing this application may be disclosed to any professional insurance company, hospital or healthcare facility, 2) that all of the information contained herein is true and correct and that if anything contained herein is false, Docs Who Care may immediately terminate any contract entered into with applicant, and 3) that applicant shall notify Docs Who Care if any of the answers or information contained herein becomes incorrect or incomplete. This release is valid for a period of one year from date below:*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name (Please Print) \_\_\_\_\_



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## PROVIDER RELEASE OF INFORMATION

In applying for assignment with **Docs Who Care**, I hereby signify my willingness to appear for interviews and consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications, including photographs of me, between **Docs Who Care** and other health care institutions (e.g.) hospitals, medical staffs, medical groups, independent practice associations, health plans, health maintenance organizations, managed care entities, other health delivery systems or entities, medical societies, professional societies, medical school faculty training programs, professional liability insurance companies, licensing authorities and business and individuals acting as their agents – collectively “Institutions”, for the purpose of evaluating my application and any recredentialing regarding my professional training, experience, character, conduct, judgment, ethics and ability to work with others. In this regard the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect peer review records from being further disclosed.

I release **Docs Who Care** and other institutions and their respective directors, officers, medical staffs, employees and agents or other independent contractors from any liability that **Docs Who Care** or other institutions may incur as a result of disclosing such information in accordance with the foregoing to the fullest extent provided under state or federal laws.

I further authorize and consent to the release of information by **Docs Who Care** to other hospitals and their medical staffs, medical associations or health care organizations on request regarding information that **Docs Who Care** may have concerning me as long as such release is done in good faith and without malice and I also release from liability **Docs Who Care** for so doing.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name *(Please Print)* \_\_\_\_\_

***A photocopy or facsimile of this document shall be as effective as the original.***

# DOCUMENT CHECKLIST

*The following is a list of required documents necessary to complete your application:*

- \_\_\_\_\_ Copy of Curriculum Vitae or Resume
- \_\_\_\_\_ Copy of Medical School Diploma
- \_\_\_\_\_ Copy of Internship, Residency, and Fellowship Certificates (as well as ECFMG, if applicable)
- \_\_\_\_\_ Copy of American Board of Family Medicine Certification
- \_\_\_\_\_ Copy of Other Certifications (ATLS, ACLS, PALS, etc)
- \_\_\_\_\_ Copy of Current State Medical License(s)
- \_\_\_\_\_ Copy of DEA(s) and State Controlled Substance License(s) (if applicable)
- \_\_\_\_\_ Copy of Certificate of Professional Liability Insurance
- \_\_\_\_\_ Copy of Kansas Health Care Stabilization Fund Coverage (if applicable)
- \_\_\_\_\_ UPIN Number
- \_\_\_\_\_ Medicaid Provider Number
- \_\_\_\_\_ NPI: National Provider Identifier Number (Must include paper confirmation from NPPES)
- \_\_\_\_\_ Recent Photograph