Staffing Application

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: ( ) _____ E-mail Address: _____

Date Available: _____ Social Security No.: _____ Desired Salary: $ _____

Position Applied for: _____ Date of Birth: _____

Are you a citizen of the United States? YES ■ NO ■ If no, are you authorized to work in the U.S.? YES ■ NO ■

Have you ever worked for this company? YES ■ NO ■ If so, when? _____

Have you ever been convicted of a felony? YES ■ NO ■

If yes, explain: _____

Do you have a friend or relative working for the company? Y or N - If yes, please list _____

Education

High School: _____ Address: _____

From: __ To: _____ Did you graduate? YES ■ NO ■ Degree: _____

College: _____ Address: _____

From: __ To: _____ Did you graduate? YES ■ NO ■ Degree: _____

Other: _____ Address: _____

From: __ To: _____ Did you graduate? YES ■ NO ■ Degree: _____

References

Please list three professional references.

Full Name: _____ Relationship: _____

Company: _____ Phone: ( ) _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: ( ) _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: ( ) _____

Address: _____

_____

Previous Employment

Company: _____ Phone: ( ) _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: $ _____ Ending Salary: $ _____

Responsibilities: _____

From: __ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES ■ NO ■

Company: _____ Phone: ( ) _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: $ _____ Ending Salary: $ _____

Responsibilities: _____

From: __ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES ■ NO ■

Company: _____ Phone: ( ) _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: $ _____ Ending Salary: $ _____

Responsibilities: _____

From: __ To: _____ Reason for Leaving: _____

Claim/Lawsuit History – 10 Year History

If you answer yes to any of the following questions, please provide details per the attached claims information sheet. Please explain any surcharge to your professional liability coverage on a separate sheet.

Have you ever been a defendant in a malpractice suit? Yes No

Have any judgments been made against you or settlements been agreed to in any professional liability case? Yes No

Are there any professional liability lawsuits pending against you at the present time? Yes No

Has your professional liability insurance ever been terminated or restricted or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance? Yes No

Health Status

If the answer to any question is "yes", reference the question on a separate sheet. Please provide a full explanation and attach.

Are you currently using any chemical substance(s), which in any way may impair or limit your ability to practice medicine with reasonable skill and safety? Yes No

Are you currently engaged in the illegal use of controlled substances? Yes No

Do you have a mental or physical condition, which in any way may impair or limit your ability to practice medicine with reasonable skill and safety with or without reasonable accommodation? Yes No

Professional Practice

Have any of the following been or are currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, reviewed, placed on probation, or placed under the disciplinary action, either voluntarily or involuntarily in this or any other state, territory or country? If "yes", provide full explanation and attach.

Medical or professional license? Yes No

DEA Registration or Controlled Substance License? Yes No

Hospital medical staff membership? Yes No

Clinical privileges or other rights on any hospital medical staff? Yes No

Employment by any hospital, institution or the military? Yes No

Professional society membership? Yes No

Participation in any private, federal, or state health insurance program (i.e. Medicare, CHAMPUS, Medicaid) Yes No

Participation in an HMO, PPO, or any other managed care organization? Yes No

Board Certification? Yes No

Other Disclosures

At any time have you ever been:

Convicted of any criminal offense in any jurisdiction? Yes No

Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition I lieu of trial, or an accelerated rehabilitation of felony charges in any state, territory or country? Yes No

Have you ever, at any time, or are you currently:

Under audit by a Health Care Agency (i.e. Medicare, Medicaid, MDCH, or any insurance) Yes No

Under indictment for crime? Yes No

The subject of an investigation by any private, federal, or state health insurance program or state, territory or country licensing board? Yes No

The subject of any adverse action reports to a state or federal agency? Yes No

Sanctioned by a government program for any reason? Yes No

Have you ever, at any time, either voluntarily or involuntarily:

Withdrawn your application for medical staff membership at any facility? Yes No

Withdrawn your request for any clinical privileges at any facility? Yes No

ORIGINAL ATTESTATION STATEMENT

I agree to the counts thereof as evidenced by my signature that the information provided in this application is true by the best of my knowledge and that omissions or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Signature: ____

Date: ____

UPDATED ATTESTATION STATEMENT

I agree to the counts thereof as evidenced by my signature that the information provided in this application is true by the best of my knowledge and that omissions or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Signature: ____

Date: ____

UPDATED ATTESTATION STATEMENT

I agree to the counts thereof as evidenced by my signature that the information provided in this application is true by the best of my knowledge and that omissions or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Signature: ____

Date: ____

UPDATED ATTESTATION STATEMENT

I agree to the counts thereof as evidenced by my signature that the information provided in this application is true by the best of my knowledge and that omissions or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Signature: ____

Date: ____

CONSENT TO RELEASE OF INFORMATION FORM

I understand that **Urban Community Action Projects** will verify statements made on my staff application and made during my staffing interview. When contacted by this company, I give permission for my former employers and educational institutions to relate information or opinions about myself, in order that I may be evaluated for staffing purposes. I hereby release these persons and/or organizations as well as **Urban Community Action Projects** from any and all liability from damages of whatever kind or nature, whether known or unknown, which may at any time accrue to me on account of information obtained pursuant to this authorization.

Nature of Employment: I understand that if I am employed or approved to serve as a volunteer by Urban Community Action Projects, my employment or volunteering can be terminated with or without cause, and with or without notice, at any time, at the option of either Urban Community Action Projects or myself. I understand that no employee, supervisor, manager, or officer of Urban Community Action Projects has any authority to enter into any agreement for employment or volunteering for any specified period of time, or to make any agreement contrary to the foregoing, except the President/CEO of the Company can make such an agreement, but such an agreement would only be valid if it was made in writing and if it was signed by the President/CEO.

Certification of Accuracy Statement: I certify that all the statements I have made on this application and related papers and in interviews are true, and I understand any falsification, misrepresentations or intentional omission may be grounds for eliminating me from further employment or volunteering consideration, rescinding an employment offer or cause for dismissal without obligation on the part of Urban Community Action Projects, except for payment to me for any employment services already rendered.

Urban Community Action Projects will not discriminate against any employee or applicant for employment because of age (as defined by applicable law), religion, sex, race, color, national origin, or because they are disabled, a disabled veteran or Vietnam era veteran or on the basis of any other characteristic protected by federal, state, or local law. Answers to questions will be utilized for applicable, job-related information only.

Credentialing

I understand that this Consent to Release Information is made in connection with Physician/Practitioner contracting, credentialing, recredentialing or reappointment activity of the Plan. I further understand that the Plan is responsible for the evaluation of my professional training, experience, professional conduct and judgment. All information submitted by me or on my behalf pursuant to this Consent to Release Information is true and complete to the best of my knowledge and belief. I fully understand that any misstatement in or omission related thereto may constitute cause for the summary dismissal/denial of such participation in the Plan. I understand and agree that as an applicant for participation with the Plan, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I hereby authorize the Plan and its representative to contact and/or consult with any persons, entities or institutions (including, but not limited to, hospitals, HMOs, PPOs, other group practices and professional liability carriers) which I have been affiliated, have used for liability insurance or who may have information relevant to my character and professional competence and qualifications, whether or not such persons or institutions are listed as references by me. I consent to the release and communication of information and documents between the Plan and persons, entities or institutions in jurisdictions in which I have trained, resided, practiced, or applied for professional licensure, privileges or membership in plans for the purpose of evaluation of my professional training, experience, character, conduct, ethics and judgment, and to determine professional liability insurance and/or malpractice insurance claims history.

I also authorize and direct persons contacted by the Plan to provide such information regarding my character and/or professional competence and qualifications, my professional liability insurance and/or malpractice insurance claims history to representatives of the Plan and I understand in doing so, I am waiving my confidentiality rights to this information. I release and hold harmless from liability all persons, entities, or institutions who, in good faith and without malice for acts performed in gathering or exchanging information in this credentialing or recredentialing process. This release and hold harmless provision applies to all persons, entities and institutions who will provide and/or receive, as part of the Plan's credentialing or recredentialing process, information which may relate to my past or present physical and/or mental condition, including substance abuse, alcohol dependency and mental health information.

I further authorize the release of the above information or any other information obtained from the application by a credentialing verification organization (CVO) to any health care organization designated by me or one that has

entered into an agreement with the CVO where I currently have, am currently applying, or in the future will be applying for participation. I also authorize the CVO or the Plan to allow my file to be reviewed by the organizations' state or national accrediting and licensing bodies.

I further affirm that I currently do not have any physical and/or mental conditions and/or impairments, such as substance abuse, alcohol dependency and/or mental health concerns which interfere with my ability to practice medicine. I agree to notify representatives of the Plan of any changes in my professional licensure, scope of hospital privileges, participating Plan status, status of my malpractice insurance, malpractice claims history information and practice locations. I understand that this application shall not be deemed complete until an on-site medical practice office review is completed, if applicable, as well as receipt of all information required by this application process. I further agree to appear before the Plan for interviews, if requested, or inquiries regarding evaluations of my professional qualifications at reasonable times and place.

A photocopy of this consent shall be as effective as an original when presented.

Practitioner's Printed Name: _____

Practitioner's Signature: _____
Date: _____

Updated Signature: _____
Date: _____

Updated Signature: _____
Date: _____

Updated Signature: _____
Date: _____

Updated Signature: _____
Date: _____

Updated Signature: _____
Date: _____

Updated Signature: _____
Date: _____