



LOCUM TENENS APPLICATION

Please fax or mail your completed application Fax Number: 414-272-3852
Concorde Staff Source, Inc. | 735 N. Water St. Suite 285 | Milwaukee 53202

**All questions must be completed in their entirety. A partial application will not be accepted.
Attach any additional pages if necessary.**

GENERAL INFORMATION (Please Print or Type)

NAME (LAST)	(FIRST)	(MIDDLE)	(SUFFIX)	DEGREE
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LIST OTHER NAMES BY WHICH YOU HAVE BEEN KNOWN: (LAST) (FIRST) (MIDDLE)

IF YOU HAVE BEEN KNOWN BY OTHER NAMES, PLEASE EXPLAIN WHY YOUR NAME CHANGED

ORGANIZATION NAME

OFFICE ADDRESS	PHONE ()
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CITY	STATE	ZIP
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MAILING ADDRESS	PHONE () CELL ()
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CITY	STATE	ZIP
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ANSWERING SERVICE NO.	PAGER NO.	FAX NO () E-MAIL
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BIRTHDATE (MM/DD/YY) / /	BIRTHPLACE	CITIZENSHIP
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SEX	MARITAL STATUS (CIRCLE ONE) S / M / D / W	NAME OF SPOUSE	EMERGENCY CONTACT & PHONE NO.
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SOCIAL SECURITY NO.	AMA NO.
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MEDICARE UNIQUE I.D. PROVIDER NO.	MEDICAID PROVIDER NO.
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UPIN NO.	NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI)
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(Contact your consultant if you do not have all of the above requested numbers)

LICENSURE: PLEASE LIST ALL MEDICAL LICENSES, CURRENT OR EXPIRED AND STATE CONTROLLED SUBSTANCE LICENSES. (ATTACH COPY OF LICENSE)

STATE	NO.	LICENSE UNLIMITED Y OR N	DATE ISSUED (MM/DD/YY) / /	DATE EXPIRES (MM/DD/YY) / /
OTHER STATE	NO.	Y OR N	/ /	/ /
OTHER STATE	NO.	Y OR N	/ /	/ /
OTHER STATE	NO.	Y OR N	/ /	/ /

IF NO, PLEASE EXPLAIN LIMITATION: _____

**CONTROLLED SUBSTANCES LICENSE:
(ATTACHED COPY OF LICENSE)**

STATE	NO.	LICENSE UNLIMITED Y OR N	DATE ISSUED (MM/DD/YY) / /	DATE EXPIRES (MM/DD/YY) / /
OTHER STATE	NO.	Y OR N	/ /	/ /

IF NO, PLEASE EXPLAIN LIMITATION: _____

**FEDERAL DEA REGISTRATION
(ATTACH COPY OF CERTIFICATE)**

NO.	LICENSE UNLIMITED Y OR N	DATE EXPIRES (MM/DD/YY) / /
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IF NO, PLEASE EXPLAIN LIMITATION: _____

EDUCATION

PRE-PROFESSIONAL UNIVERSITY	INSTITUTION		ADDRESS, CITY, STATE, ZIP	PHONE #
	DEGREE	YEAR OBTAINED	FROM (MM/DD/YY) / /	TO (MM/DD/YY) / /
MEDICAL	INSTITUTION		ADDRESS, CITY, STATE, ZIP	PHONE #
	DEGREE	YEAR OBTAINED	FROM (MM/DD/YY) / /	TO (MM/DD/YY) / /
INTERNSHIP	INSTITUTION		ADDRESS, CITY, STATE, ZIP	PHONE #
	TYPE OF INTERNSHIP PROGRAM		FROM (MM/DD/YY) / /	TO (MM/DD/YY) / /

EDUCATION (CONTINUED)

RESIDENCY	INSTITUTION	ADDRESS, CITY, STATE, ZIP	PHONE #
	TYPE OF RESIDENCY PROGRAM	FROM (MM/DD/YY)	TO (MM/DD/YY)
FELLOWSHIP	INSTITUTION	ADDRESS, CITY, STATE, ZIP	PHONE #
	TYPE OF FELLOWSHIP	FROM (MM/DD/YY)	TO (MM/DD/YY)
FELLOWSHIP/ PRECEPTORSHIP	INSTITUTION	ADDRESS, CITY, STATE, ZIP	PHONE #
	TYPE OF FELLOWSHIP/PRECEPTORSHIP	FROM (MM/DD/YY)	TO (MM/DD/YY)

*Attach copies of certificates for CPR, BLS, ACLS, etc. Hospitalists & Anesthesiologists must have certification; however some facilities may require certification for other specialties as well.

IF THE ANSWER TO ANY OF THE FOLLOWING IS YES, GIVE DETAILS ON SEPARATE SHEET

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? Yes No
2. Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil, or disciplinary action by any state or federal agency which licenses providers? Yes No
3. Has your narcotic registration to prescribe controlled substances ever been limited, suspended or revoked? Yes No
4. Have you been refused membership on a hospital medical staff? Yes No
5. Has your request for any specific clinical privileges ever been denied, granted with stated limitations, or not renewed? Yes No
6. Have your hospital privileges been changed? Yes No
- 6a. Are there any clinical privileges you have voluntarily relinquished? Yes No
7. Have you been denied membership or renewal thereof, or been subjected to disciplinary action in any local, state or national medical or dental organization? Yes No
8. Has your Board status been altered (including if your Board Certification status has lapsed due to passage of time)? Yes No
9. Have you ever been convicted of a crime (other than a traffic offense), or are you currently under indictment for an alleged crime? Yes No

10. Have you ever been the subject of any administrative, civil or criminal complaint or investigation regarding sexual misconduct? Yes No
11. Have you been hospitalized within the past five years? Yes No
12. Have you ever had any health problems (physical or mental, including substance abuse)? Yes No
13. Are you currently using illegal drugs? Yes No
14. Are there any other issues that should be disclosed that may have an adverse impact on your ability to deliver effective medical services? (If yes, please explain) Yes No
15. Have you ever had professional liability insurance refused, canceled, non-renewed, surcharged or restricted? Yes No
16. Have there ever been, or are there currently pending, any malpractice claims, suits, settlements, arbitration or other dispute resolution proceedings involving your professional practice (i.e., filing of a claim that was subsequently dropped or dismissed, request for review by medical mediation or other review panel, etc.)? . . . Yes No

If yes, please provide the following information for each situation:

- Date suit or claim was initiated (month/year)
- Brief description of the nature of the claim
- Current status, including amount of any award made

HOSPITAL AFFILIATIONS

List past and present, names and locations of all hospital, clinics, health care facilities and organizations of which you have been a staff member. Include dates of affiliation.

FACILITY, ADDRESS, CITY, STATE, ZIP	AFFILIATION FROM (MM/DD/YY)	AFFILIATION TO (MM/DD/YY)
Phone #	/ /	/ /
Phone #	/ /	/ /
Phone #	/ /	/ /
Phone #	/ /	/ /

LIABILITY INSURANCE

PRESENT CARRIER (ATTACH COPY OF LIABILITY INSURANCE CERTIFICATE)	EXPIRATION DATE (MM/DD/YY) / /
NAME, ADDRESS, CITY, STATE, ZIP	LIABILITY LIMITS /
Phone #	POLICY NO.
LIST CARRIERS WITHIN THE PAST FIVE YEARS	EXPIRATION DATE (MM/DD/YY) / /
NAME, ADDRESS, CITY, STATE, ZIP	LIABILITY LIMITS /
Phone #	POLICY NO.

(PLEASE INCLUDE ADDITIONAL CARRIER INFORMATION)

BOARD CERTIFICATION

Are you certified by a Specialty Board recognized by the American Board of Medical Specialties, American Osteopathic Board, or Royal College of Physicians and Surgeons of Canada? Yes No

(ATTACH COPY OF CERTIFICATE) BOARD OF	CERTIFIED-DATE (MM/DD/YY) / /	RECERTIFIED-DATE (MM/DD/YY) / /
(ATTACH COPY OF CERTIFICATE) BOARD OF	CERTIFIED-DATE (MM/DD/YY) / /	RECERTIFIED-DATE (MM/DD/YY) / /
(ATTACH COPY OF CERTIFICATE) BOARD OF	CERTIFIED-DATE (MM/DD/YY) / /	RECERTIFIED-DATE (MM/DD/YY) / /

If not certified, are you admissible for certification examination by a Specialty? Yes No
If yes, which board.

BOARD OF _____ DATE _____ / _____ / _____

If No, have you taken or are you scheduled to take the specialty board's certification? Y or N

If certifying boards taken, give date _____
(Mm/yy)

Certification expiration date, if any _____
(Mm/yy)

If not taken, date scheduled to take specialty boards _____
(Mm/yy)

HEALTH STATUS

DESCRIBE CURRENT HEALTH STATUS

LAST EXAMINATION (MM/DD/YY)

BY (NAME, ADDRESS, CITY, STATE, ZIP)

/ /

It is necessary to provide documentation of current immunization in some states.Rubella Titer Rubeola (Measles) Hepatitis B Mumps TB Skin Test Chicken Pox (Varicella)

(PLEASE ATTACH COPY OF RECORDS)

REFERENCES

Provide a minimum of three professional references that have had an opportunity to extensively work with and observe your medical practice within the last two years, preferably as a preceptor or associate, and can provide an evaluation of your professional competence and ethical character.

NAME	TITLE	PHONE
		FAX
ORGANIZATION	ADDRESS, CITY, STATE, ZIP	
NAME	TITLE	PHONE
		FAX
ORGANIZATION	ADDRESS, CITY, STATE, ZIP	
NAME	TITLE	PHONE
		FAX
ORGANIZATION	ADDRESS, CITY, STATE, ZIP	
NAME	TITLE	PHONE
		FAX
ORGANIZATION	ADDRESS, CITY, STATE, ZIP	

RISK MANAGEMENT DOCUMENTATION CHECKLIST:

In order to complete the Risk Management process for your assignment we need the following documents:

- Complete application including signed release and authorization page
- Curriculum Vitae
- Medical School Diploma
- ECFMG (if applicable)
- Internship Certificate
- Residency Certificate
- Fellowship Certificate (if applicable)
- Specialty Board Certificate
- Flex, National Boards or USMLE
- DEA Registration / State Controlled Substances License
- State Medical Licenses
- Liability Insurance Certificate
- Immunization Documentation
- National Provider Identifier (NPI) – copy of original email letter
- Driver’s license or Passport
- CME certificates (15 hours within last 3 years)

* (For Radiologists who will be doing Mammography)

- Mammography (MQSA) Documentation of 960 Mammo. Interpretations within the last 2 years
and 15 hours CME within the last 3 years

RELEASE, AUTHORIZATION AND ACKNOWLEDGMENT:

In making application to Concorde Staff Source:

I certify that the above information I have provided on this application and attachments is true and accurate, that it can be used by Concorde for evaluating my potential as a Locum Tenens physician, and that Concorde will rely on the truthfulness of my application.

I acknowledge in making medical application for membership to the medical staff, I authorize Concorde and its representatives, to obtain any information that may be relevant to an evaluation of my professional qualifications, including information about disciplinary actions or other credentials or confidential information.

I hereby release Concorde, its officers, employees, and representatives, and third parties which provide or receive information regarding my credentials. Further, I agree to indemnify, defend and hold Concorde harmless, from any and all claims, causes of action, damages, judgments and expenses, including reasonable attorney's fees, arising from or related to the collection, verification and dissemination of my credentialing information.

I understand that I have the burden of providing accurate information to Concorde to demonstrate my qualifications. I understand that any misrepresentation on this application may constitute grounds for denial or referral to practice assignments.

I understand that I am responsible for notifying Concorde of any changes affecting my professional status. I certify that the information contained in this application is accurate and complete.

I acknowledge that I am not an employee of Concorde and that any services I may provide to a Concorde client will be provided as an independent contractor.

I understand the information provided by references is confidential and will not be released without their consent.

I understand that the decision to refer me to potential opportunities is at the discretion of Concorde. I agree that if I am referred by Concorde to any opportunity I will promptly notify Concorde each time I provide any Locum Tenens services to that Concorde client, or to any affiliate of that client, within two years of such initial referral or introduction or within two years of the performance of any covered locum tenens services, whichever is later.

APPLICANT'S SIGNATURE

DATE