COASTAL HEALTHCARE RESOURCES

Phone: 843-679-3251
Toll Free: 866-877-2762
Fax: 866-992-7144

PO Box 6467
700 S. Parker Drive, Suite 7
Florence, SC 29502

Anesthesia Professional Application Packet

Thank you for downloading our application packet, please follow the steps below to ensure we receive your application for review:

1. Please fill out all applicable fields in this application.

2. After you have completed the application, **SAVE** this as a PDF:

You may save this document with your information at any time by selecting: **File > Save** from the top left menu in Adobe Reader. You may also click on the orange button in this document that says "Click here to save your changes". This will save a copy of the PDF with your changes.

You may overwrite the previous PDF after you have made your desired changes.

3. Open your preferred email service (Outlook, Gmail, AOL..etc). Compose a new email. The send "TO:" address should be: rmcdougald@coastalhcresources.com , please make the subject of the email "Application Packet Submission".

4. Attach to the email the **SAVED PDF** that you filled out with your information.

5. Send the email. We will contact you to confirm we received your submission. Please allow up to 24 hours.

Please contact rmcdougald@coastalhcresources.com regarding any questions about this document.

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ANESTHESIA PROFESSIONAL INFORMATION PACKET

PERSONAL INFORMATION

Full Name _____ Maiden/Former Name _____

Street Address _____

City, State, Zip _____ Home Phone _____

Business Name and Tax ID number _____ Mobile Phone_____

Marital Status _____ Citizenship: _____ Pager_____

Birth Place (City, County, State) _____ Fax_____

Birth Date _____ SSN _____ Email_____

Emergency Contact (relation to you) _____

CAQH User Name:_____ CAQH Password:_____

NPPES User Name:_____ NPPES Password:_____

CERTIFICATION/LICENSURE

AANA CERTIFICATION # _____ Initial date of certification _____ Expiration Date _____

DO YOU HAVE CURRENT CERTIFICATION: ACLS ☐ **BLS** ☐ **PALS** ☐ **NALS** ☐

PROFESSIONAL LICENSES	**State**	**License Number**	**Date Issued**	**Expiration Date**
*Please list ALL **current** state licenses and advanced practice if applicable.*				
Place an (*) next to Licensure that is pending approval.				

State of Original Licensure_____ **Date**_____

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WORK PREFERENCES

At Coastal Healthcare Resources INC., we work hard to meet your clinical and working preferences.
Please help us to cater to these needs by completing your "Preferences."
Please e-mail to info@coastalhcresources.com or mail to PO BOX 6467; Florence, SC 29502.

DATE_____ *Please place an (*) by preferred contact method.*

NAME _____ Home _____

ADDRESS_____ Pager _____

_____ Fax _____

STATES CURRENTLY LICENSED: _____ Work _____

Mobile _____ E-mail _____

CURRENT STATUS

Are you currently employed? ☐ Status: full-time ☐ part-time ☐ temp/prn ☐ locums ☐ other: ☐

Do you carry your own liability insurance? ☐ Limits_____ Carrier_____ Exp Date_____

Name of all facilities/group(s) in which you currently have privileges to practice (credentialed):_____
_____

REGIONAL PREFERENCE

In what state, regional area, or distance from home are you interested in working? _____
_____

HOURS

How often would you like to work (ie: 8hrs-40hrs/week, short-term/long term assignments)? _____

Please specify desired hours:

☐ OURS: Less than 20 / week
☐ 20 – 40 / week
☐ 40 + / week

☐ CALL: no call
☐ weekday call
☐ weekend call

OTHER:

ANESTHESIA PRACTICE PREFERENCES

SETTING (circle all that apply):

☐ "solo" practice setting
☐ "team Based" setting (MDA/CRNA)
☐ Hospital setting
☐ office-based anesthesia setting

Cases (circle):

☐ OB ☐ Pediatrics ☐ Thoracic ☐ Hearts
☐ Trauma ☐ Transplant ☐ Neuro ☐ Vasculas
☐ Outpatient ☐ General Surgery ☐ Plastics ☐ ENT
☐ Regional ☐ Other

AVAILABILITY

What is your earliest availability for a work assignment? (an explanation may be necessary)
_____
_____

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PROFESSIONAL LIABILITY INSURANCE

INSURANCE CARRIER_____

Complete Address _____

Policy Number_____ Claim/Aggregate Limits_____

Effective Date _____ Expiration Date_____ Years with Company _____

EDUCATION

UNDERGRADUATE NURSING

Name of Program_____

Address_____

Phone _____ Fax_____

Dates Attended_____ Degree_____

GRADUATE ANESTHESIA PROGRAM

Name of Program_____

Address_____

Phone _____ Fax_____

Dates Attended_____ Degree_____

Other

Name of Program_____

Address_____

Phone _____ Fax_____

Dates Attended_____ Degree_____

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WORK HISTORY

***In chronological order**, please list your professional health care work history for the **past 5 years** including all hospitals, corporations, government or military assignments. If additional space is needed, please use the back of this form or attach additional sheets.*

1) Dates _____ **Status of employment**_____
Name of Hospital _____
Address_____
Contact person _____ Title_____
Phone _____ Fax_____

2) Dates _____ **Status of employment**_____
Name of Hospital _____
Address_____
Contact person _____ Title_____
Phone _____ Fax_____

3) Dates _____ **Status of employment**_____
Name of Hospital _____
Address_____
Contact person _____ Title_____
Phone _____ Fax_____

4) Dates _____ **Status of employment**_____
Name of Hospital _____
Address_____
Contact person _____ Title_____
Phone _____ Fax_____

5) Dates _____ **Status of employment**_____
Name of Hospital _____
Address_____
Contact person _____ Title_____
Phone _____ Fax_____

6) Dates _____ **Status of employment**_____
Name of Hospital _____
Address_____
Contact person _____ Title_____
Phone _____ Fax_____

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PLEASE ANSWER THE FOLLOWING QUESTIONS:

If yes to any of the following questions, please attach a detailed information sheet

Have you ever had a state license or certification to practice your profession relinquished, denied, limited, revoked or suspended, either voluntarily or involuntarily?
YES_____ NO_____

Have any investigations or disciplinary actions ever been initiated and/or are any now pending against you by a state license board, certification agency or professional organization?
YES_____ NO_____

Have you ever been convicted of a felony or misdemeanor relating to the practice of your profession, other health care related matters, third-party reimbursement, violence, controlled substance violation, or anything other than a minor traffic violation?
YES_____ NO_____

Have you ever had hospital privileges denied, revoked, suspended, or voluntarily surrendered?
YES_____ NO_____

Have you ever had disciplinary action or been denied membership/renewal in any professional society organization?
YES_____ NO_____

Have you ever been the subject of investigation by or been suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health insurance program (ie: Medicare or Medicaid)?
YES_____ NO_____

If yes to any of the following questions, please attach a detailed information sheet. Please include name of court in which suit was filed, caption and docket number of case, name and address of attorney defending you, and any other relevant details.

Have you ever been named as a defendant in any criminal proceeding?
YES_____ NO_____

Has your professional liability insurance ever been terminated by action of an insurance company?
YES_____ NO_____
If yes, state when and by what company.

Have you ever been denied professional liability coverage?
YES_____ NO_____
If yes, state when and by which company.

Have you ever been rated in a higher than average risk class for your profession, or had an additional premium imposed upon you because of your claims history?
YES_____ NO_____

Have any professional liability suits been filed against you?
YES_____ NO_____

Have any professional liability suits been filed against you of which are presently pending?
YES_____ NO_____

Have any judgments been made against you in a professional liability case/claim, or have you entered into any settlements?
YES_____ NO_____

If yes to any of the following questions, please include a sheet of detailed information.

Are you able to perform all physical and mental functions, with or without accommodation, necessary to provide patient care services for which you are seeking clinical privileges?
YES_____ NO_____ *If no, please explain.*

Are you presently taking medications or other substances that could limit your ability to perform the clinical privileges of which you are seeking?
YES_____ NO_____

Have you ever had treatment for alcohol abuse and/or substance abuse?
YES_____ NO_____

Are you currently engaged in any rehabilitation program?
YES_____ NO_____

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Please list the following information for each malpractice claim that has been filed/dismissed/closed/settled against you, on or before 1990:

- Complete the "Malpractice Claim Information" form attached
- Provide at least ONE of the 3rd party documentations listed below(correspondence must be on the sender's letterhead, include the plaintiff's name, date of incident and allegations):

Finalized Claims:

- **Final court order or settlement agreement-** May be obtained from the records department of the county court where the claim was filed.
- **Insurance Company/Legal Counsel Correspondence-** Claims History/Loss Run
- **National Practitioner Data Bank Self Query**- Report cannot be older than 90 days old from when you sign your application. Can be obtained by calling the NPDB (800-767-6732) or by visiting their website (http://www.npdb-hipdb.hrsa.gov/index.jsp) and following the directions for self queries. This option is only suitable for claims filed on or before 1990.
- **Facility Correspondence-** May be obtained from the Legal or Risk Management Department of your facility
- **United States Government-** If the claim occurred at a Government facility & you were covered under the Federal Tort Claims Act, the Legal or Risk Management Department should be able to assist you in obtaining a letter from the facility.

IF THE CLAIM IS FINALIZED, ALL LETTERS MUST STATE THE OUTCOME & TOTAL INDEMNITY PAID ON YOUR BEHALF.

Pending Claims:

- Legal Counsel Correspondence- Must meet the above requirements & state that the case is "defensible".

In some cases, Coastal Healthcare Resources may request additional forms of third party information. Please contact the office should you have any questions.

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You may photocopy this from if additional forms are needed.

Employee Name_____

Claimant Name_____

Location of Occurrence (Facility, City, State): _____

Date of Occurrence_____

Description of Occurrence and Details of Claim(attach a sheet if necessary):

_____
_____
_____

Outcome:

☐ Pending

☐ Withdrawn by Claimant

☐ Dismissed/Settled/Closed with no payment

☐ Dismissed/Settled/Closed with payment

Total Claim Payment: $_____

Claim payment on your behalf: $_____

Amount paid by Insurance Carrier $_____

Amount paid by Compensation Fund $_____

Insurance Information (Name, Policy Number, Contact Number):_____

_____

Legal Counsel Information (Name, Address, Contact Number):_____

_____

Employee Signature:_____

Date:_____

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STATEMENT OF HEALTHCARE PROFESSIONAL

(Authorization for Release of Information)

I, _____, HEREBY CONFIRM THAT ALL INFORMATION GIVEN IN OR ATTACHED TO THIS PROVIDER DATA SHEET IS ACCURATE AND VOLUNTARILY SUPPLIED BY MYSELF.

I hereby authorize Coastal Healthcare Resources, its affiliates and successors, to obtain any information that may be relevant to an evaluation of my professional qualifications, including information pertaining to disciplinary actions, criminal background and history, or other confidential or privileged information, and other credentials.

I authorize Coastal Healthcare Resources to disclose to current, prior, or potential employers making a reasonable inquiry, information relating to my qualifications, ability, and character.

Only to the extent requested and required by the practices, facilities, groups and hospitals staffed by Coastal Healthcare Resources where I will be providing clinical services, I agree to provide and authorize the release of the same by Coastal Healthcare Resources to Coastal Healthcare Resources clients, the following: a) vaccination records; b) reasonable documentation evidencing that I am in good health and free of communicable diseases; c) the result of and/or a copy of my criminal background check, if any and d) the result of and/or a copy of my drug screen, if any.

I hereby release Coastal Healthcare Resources, its officers, employees, and agents, and third parties which provide or receive information regarding my credentials, including, but not limited to, all credentialing information sources, individuals or companies who provide references, companies or agencies that perform clinical background checks, and companies that perform drug screens, from any claims, causes of action, damages and expenses, including reasonable attorney's fees arising from or relating to the collection, verification, an dissemination of my credentialing and other information.

I agree to hold Coastal Healthcare Resources harmless from and against any and all claims, causes of action, damages, judgments and expenses, including reasonable attorney's fees, arising from or related to the accuracy of the information provided by me. I understand that this does not contemplate a duty to hold Coastal Healthcare Resources harmless from claims, causes of action and damages which may arise as a result of information provided about me from sources other than me.

This is a continuing authorization and shall be effective from the date of signature below until such time as I have specifically revoked the same in writing.

If any material changes occur affecting my professional status, it is my obligation to notify Coastal Healthcare Resources or the appropriate affiliate or successor as soon as possible. I understated that the decision to employ me or refer me to practice opportunities is solely at the discretion of Coastal Healthcare Resources.

I understand that any information received from references is confidential and may not be released to me without the consent of the reference. I understand, agree and acknowledge that references are not part of my personnel file.

A copy or facsimile of this document shall have the same effect as the original.

This document shall be interpreted according to the laws of the state of South Carolina.

Name_____ Social Security number_____

Signature_____ Date_____