Visiting Physicians Association®
Corporate Office:
500 Kirts Blvd.
Troy, MI 48084
(248) 824-6000 Telephone
(248) 824-6001 Fax

EMPLOYMENT APPLICATION/CREDENTIALING FORM FOR MEDICAL STAFF

- Complete every section in its entirety
- Print or type all entries
- Use additional sheets, if necessary

A CHECKLIST INFORMATION

IMPORTANT: Please enclose the following documents:

PHYSICIANS

1. Curriculum Vitae
2. Copy of all State Physicians Licenses
3. Copy of any State Controlled Substance Licenses
4. Copy of DEA Certificate
5. Copy of American Board Cert. or Eligibility Confirmation
6. Appropriate Identification
   a. Proof of Identity/Photo ID
   b. Legal Work Authorization
7. Copy of current Liability Coverage
8. Copies of Med. School Diploma/Intern/Residency Certs.
9. ECFMG Certificate (if applicable)
10. Copies of ACLS and/or BLS Certs.

NP/PA

1. Curriculum Vitae
2. Copy of all State NP/PA Licenses
3. Copy of any State Controlled Substance Licenses
4. Copy of DEA Certificate
5. Appropriate Identification
   a. Proof of Identity/Photo ID
   b. Legal Work Authorization
6. Copy of current Liability Coverage
7. Copy of NP/PA Program Diploma
8. Copies of ACLS and/or BLS Certs.

B PERSONAL INFORMATION

Last Name: _____ First Name:_____M.I.: _____ Date:_____

Present Home Address: _____ City: _____State:_____ Zip: _____

Present Professional Address: _____ City: _____State:_____ Zip: _____

Home Phone: ( )_____ Work Phone: ( )_____

Social Security Number: _____ Cell/Beeper Number: ( ) _____

Date of Birth: _____ Place of Birth (City/State/Country):_____

Citizenship:_____ NPI#:_____ CAQH#: _____

Medicare PIN#: _____Medicaid PIN#_____ Medicare UPIN#: _____

What languages are you fluent in? _____

Have you ever worked for Visiting Physicians? _____ If yes, list dates of employment: _____

If yes, list reason for leaving Visiting Physicians: _____

How did you hear about Visiting Physicians? _____

Why do you want to work for Visiting Physicians?_____

_____

_____

C EDUCATION

UNDERGRADUATE SCHOOL

INSTITUTION				
ADDRESS	CITY	STATE	COUNTRY	ZIP
PHONE	DEGREE	DATES FROM / / TO / /		

MEDICAL SCHOOL

INSTITUTION				
ADDRESS	CITY	STATE	COUNTRY	ZIP
PHONE	DEGREE	DATES FROM / / TO / /		

LIST ALL INTERNSHIPS, FELLOWSHIPS, AND OTHER POSTGRADUATE TRAINING IN CHRONOLOGICAL ORDER

TYPE (INTERNSHIP, RESIDENCY, FELLOWSHIP, OTHER)		INSTITUTION		
ADDRESS	CITY	STATE	COUNTRY	ZIP
PHONE	SPECIALTY	DATES FROM / / TO / /		
PROGRAM DIRECTOR		PROGRAM COMPLETED? YES NO		

TYPE (INTERNSHIP, RESIDENCY, FELLOWSHIP, OTHER)		INSTITUTION		
ADDRESS	CITY	STATE	COUNTRY	ZIP
PHONE	SPECIALTY	DATES FROM / / TO / /		
PROGRAM DIRECTOR		PROGRAM COMPLETED? YES NO		

TYPE (INTERNSHIP, RESIDENCY, FELLOWSHIP, OTHER)		INSTITUTION		
ADDRESS	CITY	STATE	COUNTRY	ZIP
PHONE	SPECIALTY	DATES FROM / / TO / /		
PROGRAM DIRECTOR		PROGRAM COMPLETED? YES NO		

TYPE (INTERNSHIP, RESIDENCY, FELLOWSHIP, OTHER)		INSTITUTION		
ADDRESS	CITY	STATE	COUNTRY	ZIP
PHONE	SPECIALTY	DATES FROM / / TO / /		
PROGRAM DIRECTOR		PROGRAM COMPLETED? YES NO		

D CHRONOLOGICAL PROFESSIONAL HISTORY

Please provide all employers, locum tenens, clinics, private or group practice, and/or military service in chronological order. Account for ALL intervals of time not included in Section D. Do not include internships, residencies, or fellowships in this section. List additional institutions on a separate page.

P.C./CLINIC/EMPLOYER			DATES FROM / / TO / /	
ADDRESS	CITY	STATE	COUNTRY	ZIP
PHONE	STAFF CATEGORY	DEPARTMENT		
CHIEF OF STAFF	DEPARTMENT CHIEF	OFFICES HELD (IF ANY)		
CAPACITY OF POSITION IF NOT IN A HOSPITAL				

P.C./CLINIC/EMPLOYER			DATES FROM / / TO / /	
ADDRESS	CITY	STATE	COUNTRY	ZIP
PHONE	STAFF CATEGORY	DEPARTMENT		
CHIEF OF STAFF	DEPARTMENT CHIEF	OFFICES HELD (IF ANY)		
CAPACITY OF POSITION IF NOT IN A HOSPITAL				

P.C./CLINIC/EMPLOYER			DATES FROM / / TO / /	
ADDRESS	CITY	STATE	COUNTRY	ZIP
PHONE	STAFF CATEGORY	DEPARTMENT		
CHIEF OF STAFF	DEPARTMENT CHIEF	OFFICES HELD (IF ANY)		
CAPACITY OF POSITION IF NOT IN A HOSPITAL				

P.C./CLINIC/EMPLOYER			DATES FROM / / TO / /	
ADDRESS	CITY	STATE	COUNTRY	ZIP
PHONE	STAFF CATEGORY	DEPARTMENT		
CHIEF OF STAFF	DEPARTMENT CHIEF	OFFICES HELD (IF ANY)		
CAPACITY OF POSITION IF NOT IN A HOSPITAL				

E UNACCOUNTED INTERVALS

Are there any intervals in your practice history that are unaccounted for on your application? If so, indicate the following and provide explanation on a separate sheet:

SUSPENDED FROM PRACTICE	DATES FROM / / TO / /
LOSS OF LICENSE	DATES FROM / / TO / /
SERVED IN THE MILITARY	DATES FROM / / TO / /
IMPRISONMENT	DATES FROM / / TO / /
OTHER: REASON	DATES FROM / / TO / /

F LICENSURE

List all current and past state licenses or registrations.

STATE/FEDERAL	LICENSE NUMBER	DATE ISSUED	EXPIRATION DATE	STATUS
1. License to practice		/ /	/ /	
STATE/FEDERAL	LICENSE NUMBER	DATE ISSUED	EXPIRATION DATE	STATUS
2. Federal DEA		/ /	/ /	
STATE/FEDERAL	LICENSE NUMBER	DATE ISSUED	EXPIRATION DATE	STATUS
3.		/ /	/ /	
STATE/FEDERAL	LICENSE NUMBER	DATE ISSUED	EXPIRATION DATE	STATUS
4.		/ /	/ /	
STATE/FEDERAL	LICENSE NUMBER	DATE ISSUED	EXPIRATION DATE	STATUS
5.		/ /	/ /	
STATE/FEDERAL	LICENSE NUMBER	DATE ISSUED	EXPIRATION DATE	STATUS
6.		/ /	/ /	
STATE/FEDERAL	LICENSE NUMBER	DATE ISSUED	EXPIRATION DATE	STATUS
7.		/ /	/ /	

LICENSURE EXAMS

	CERTIFICATE NUMBER	ISSUE DATE
NATIONAL BOARD		/ /
FLEX EXAM		/ /
STATE BOARD		/ /
ECFMG (If foreign medical school graduate)		/ /

G AMERICAN BOARD CERTIFICATION

BOARD CERTIFICATION

SPECIALTY BOARD	CERTIFICATE NUMBER	ISSUE DATE	EXPIRATION DATE	RE-CERTIFICATION DATE
1.		/ /	/ /	/ /
SPECIALTY BOARD	CERTIFICATE NUMBER	ISSUE DATE	EXPIRATION DATE	RE-CERTIFICATION DATE
2.		/ /	/ /	/ /
SPECIALTY BOARD	CERTIFICATE NUMBER	ISSUE DATE	EXPIRATION DATE	RE-CERTIFICATION DATE
3.		/ /	/ /	/ /

BOARD QUALIFIED

SPECIALTY BOARD	DATE QUALIFIED TO APPLY FOR EXAM	EXPIRATION DATE OF QUALIFICATION	DATE INTENDED TO TAKE EXAM
1.	/ /	/ /	/ /
SPECIALTY BOARD	DATE QUALIFIED TO APPLY FOR EXAM	EXPIRATION DATE OF QUALIFICATION	DATE INTENDED TO TAKE EXAM
2.	/ /	/ /	/ /

Have you ever taken and not passed the American Board Examination? _____Yes _____No

If yes, list date and what parts, if any, of the examination have been passed: _____/_____/_____

_____

_____

H CONTINUING MEDICAL EDUCATION

Please attach copies of CME certificates or comprehensive CME lists for past 3 years and evidence of ACLS/BLS.

I CERTIFICATIONS

Do you hold any of the following certifications? If yes, provide expiration dates and evidence.

	YES	NO	
BASIC LIFE SUPPORT			EXPIRATION DATE / /
CPR			EXPIRATION DATE / /
ADV CARDIAC LIFE SUPPORT			EXPIRATION DATE / /
NEONATAL ADV LIFE SUPPORT			EXPIRATION DATE / /

	YES	NO	
ADV LIFE SUPPORT IN OB			EXPIRATION DATE / /
ADV TRAUMA LIFE SUPPORT			EXPIRATION DATE / /
PEDIATRIC ADVANCED LIFE SUPPORT			EXPIRATION DATE / /

J PROFESSIONAL MEMBERSHIPS, SOCIETIES, ORGANIZATIONS & HONORS

ORGANIZATION	DATES
1.	/ /
ORGANIZATION	DATES
2.	/ /
ORGANIZATION	DATES
3.	/ /
ORGANIZATION	DATES
4.	/ /
ORGANIZATION	DATES
5.	/ /

K BIBLIOGRAPHY

Attach list of scientific papers, essays, books or chapters you have written if not on CV.

L PROFESSIONAL REFERENCES

List individuals other than those listed elsewhere in this application who have observed your clinical performance during a recent period.

NAME		PHONE	FAX	
ADDRESS	CITY	STATE	COUNTRY	ZIP
PROFESSIONAL RELATIONSHIP		LENGTH OF RELATIONSHIP		

NAME		PHONE	FAX	
ADDRESS	CITY	STATE	COUNTRY	ZIP
PROFESSIONAL RELATIONSHIP		LENGTH OF RELATIONSHIP		

NAME		PHONE	FAX	
ADDRESS	CITY	STATE	COUNTRY	ZIP
PROFESSIONAL RELATIONSHIP		LENGTH OF RELATIONSHIP		

M MALPRACTICE CLAIMS/SUIT HISTORY

Please copy this form for each additional claim/suit.

NAME OF CLAIMANT
DATE OF INCIDENT
DATE LAWSUIT FILED
NAME OF COURT AND CASE NUMBER
NATURE OF ALLEGATIONS OF WRONGDOING/NEGLIGENCE

STATUS OF CASE (WITH REFERENCE TO YOU SPECIFICALLY)

☐ PENDING ☐ DISMISSED FROM CASE WITHOUT PAYMENT ☐ PRE-TRIAL SETTLEMENT ($_____)

☐ VERDICT FOR DEFENDANT ☐ VERDICT FOR PLAINTIFF ($_____)

WHAT WAS/IS YOUR STATUS?

☐ SOLE DEFENDANT ☐ CO-DEFENDANT (WITH_____) ☐ OTHER (_____)

NAME & PHONE NUMBER OF INSURANCE CARRIER
NAME & PHONE NUMBER OF DEFENSE ATTORNEY
NAME & PHONE NUMBER OF PLAINTIFF'S ATTORNEY
PROVIDE ANY NAMES AND PHONE NUMBERS OF OTHERS WHO COULD PROVIDE ADDITIONAL INFORMATION REGARDING THIS CLAIM/SUIT

COMMENTS

N HEALTH HISTORY

If the answer is YES to any of the following questions, please provide full details on a separate page including names and addresses of physicians/hospitals involved. You may request a private conference to discuss these details. Please see job description for complete information.

	YES	NO
1. Do you have any condition that would compromise your ability to perform any of the mental or physical functions related to the specific clinical privileges and/or participation status you are requesting?		
2. Have you ever engaged in the unlawful use or distribution of legal drugs or the use of illegal drugs?		
3. Have you had any major surgical procedures or major illnesses, including emotional or chronic illness that would compromise your ability to perform any of the mental or physical functions related to the specific clinical privileges and/or participation status you are requesting?		

O PROFESSIONAL SANCTIONS

If the answer is YES to any of the following questions, please provide full details on a separate sheet.

PRIVILEGES	YES	NO
3. Have your clinical privileges at any other hospital or healthcare institution been limited, suspended, revoked, denied, reduced, voluntarily relinquished, not renewed, or subject to probationary conditions, or have proceedings toward any of those ends been instituted or recommended by a medical staff official, committee, or governing board?		
4. Has your medical staff membership or medical staff status at any hospital ever been limited, suspended, revoked, denied, reduced, voluntarily relinquished, not renewed, or subject to probationary conditions, or have proceedings toward any of those ends been instituted or recommended by a medical staff official, committee, or governing board?		
3. Have you been denied membership on any hospital medical staff, or healthcare institution or advancement in medical staff status, or has such a denial been recommended by a medical staff official, committee, or governing board?		
4. Has your request for any specific clinical privileges been denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship) or has such a denial or limitation been recommended by a medical staff official, committee, or governing board?		
5. Have you voluntarily relinquished any medical staff membership or clinical privileges while under investigation or disciplinary action?		
6. Have you ever been reported to the National Practitioner Data Bank?		

LICENSES/CERTIFICATIONS	YES	NO
7. Have proceedings ever been instituted by any state to have your license to practice limited, suspended, revoked, reduced, not renewed, denied or subject to censure, reprimand or probationary conditions?		
8. Have proceedings ever been instituted to have your DEA license or other state controlled substance authorization denied, not renewed, revoked, reduced, or suspended?		
9. Have proceedings ever been instituted to have your specialty board certification denied, revoked, or suspended?		
10. Have you ever voluntarily relinquished or not renewed your license to practice?		

OTHER APPOINTMENTS	YES	NO
11. Has your academic appointment or appointment status at any healthcare institution or university ever been limited, suspended, revoked, denied, reduced, not renewed, or subject to probationary conditions, or have proceedings toward any of those ends been instituted or recommended by an official, committee, or governing board?		
12. Has your professional society membership or fellowship ever been limited, suspended, revoked, denied, reduced, not renewed, or subject to probationary conditions, or have proceedings toward any of those ends been instituted or recommended by an official, committee, or governing board?		
13. Has your professional office to which you were elected or appointed ever been limited, suspended, revoked, denied, reduced, not renewed, or subject to probationary conditions, or have proceedings toward any of those ends been instituted or recommended by an official, committee, or governing board?		

OTHER SANCTIONS	YES	NO
14. Have you ever been convicted of a crime? If yes, please explain.		
15. Except with regard to individual claims, have you ever been denied the right to treat or to be paid for treatment of patients by any third party payor or governmental agency?		
16. Has there ever been any history of ranking or sanction process brought against you by a PRO or PRSO?		
17. Have you ever opted out of the Medicare program? If so, how long ago?		
18. Has there ever been any history of expulsion or payment suspension brought against you by Medicare or Medicaid?		
19. Have you ever been denied participation in an HMO or PPO?		

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Visiting Physicians Association (VPA, P.C.) and its representatives to consult in written or verbal form with the administrators and medical staff members of other hospitals and institutions with which I have associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent that VPA and its representatives may inspect all records and documents from other hospitals and institutions with which I have associated, including medical records that may be relevant to evaluating my professional qualifications and competence to carry out the clinical privileges required for staff membership at VPA. I hereby release from liability VPA and its representatives for their acts performed in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for employment status, and hereby consent to the release of such information to VPA.

I understand that if I am employed, any misrepresentation or omission made by me on this application will be sufficient cause for cancellation of this application or immediate discharge from employer's service, whenever it is discovered.

I hereby authorize that the information I supplied on this form is correct and that I have not omitted any material information. I agree that any misrepresentation or omission may be cause for ineligibility or disaffiliation by VPA.

I understand that if I am hired, I will be required to provide proof of identity and legal work authorization.

I understand and agree that acceptance of this application does not constitute approval or acceptance of employment with VPA, P.C. and grants me no rights or privileges until such time as I receive notice of employment status.

I also agree to notify VPA, P.C. of any changes made or proposed in the status of my professional license to practice, DEA or other controlled substance registration, malpractice insurance coverage, malpractice claims payment or judgments at trial, membership in or clinical privileges at any hospital, health care facility, or health care organization, or any felony convictions.

I hereby represent that I have read and fully understand the foregoing and that all information submitted by me in this application is true and complete to the best of my knowledge.

Signature of Applicant_____ Date_____