Neighborhood Health Association
Employment Application
For
Contract Licensed Associates

NEIGHBORHOOD
Health Association

This application is only to be used for contract licensed NHA associates. It must be completed in full (as appropriate to your intended position) and signed. An incomplete application could disqualify you for employment with the Neighborhood Health Association. If additional space is required, please use the "additional information" section of this application.

PLEASE PRINT OR TYPE ALL INFORMATION Date_____

1. Position for which you are applying: _____

2. Applicant's Name _____
   Last First MI

   Street Address _____
   Number Street Name Apartment No.

   _____
   City State Zip Code

3. Home Phone Number _____ Cell Phone Number _____

4. Applicant's Social Security # _____ - _____ - _____

5. Have you been convicted of or plead no contest to a crime? ☐ Yes ☐ No

If "yes," please explain:

_____

_____

6. Do you have any relatives currently employed at NHA? ☐ Yes ☐ No

   If yes, please name: _____

EDUCATION

7. Degree earned which qualifies you for this position (please be specific, do not use initials):

_____ _____
Degree Year of Graduation

8. Name of institution where this degree was earned:

_____
Name of Institution

_____
Street Address

_____
City State Zip

9. Please list any post-graduate studies in which you have a degree:

Degree_____ Yr. of Graduation_____

Degree_____ Yr. of Graduation_____

10. Please list any Internships or Residencies completed:

A. Internship ☐ Residency ☐ Area: _____

Name of Institution where completed: _____

Address: _____

City State Zip _____ Year Completed_____

B. Internship ☐ Residency ☐ Area: _____

Name of Institution where completed: _____

Address: _____

City State Zip _____ Year Completed_____

CERTIFICATIONS AND SPECIALTIES

11. Are you Board Certified: ☐ Yes ☐ No If yes, in what areas:_____

Certification #_____ Effective Date _____ Expiration _____

12. Are you Board Eligible: ☐ Yes ☐ No If yes, in what area(s) _____

When will this eligibility expire: _____

13. What is your specialty: _____ Sub-specialty _____

LICENSES and PROVIDER NUMBERS

14. Please list any licenses you may have which qualify you for this position:

A. License: _____ State where obtained_____ #_____

Date originally issued: _____ Expiration date of current license _____

B. License: _____ State where obtained_____ #_____

Date originally issued: _____ Expiration date of current license _____

C. What is your National Provider Identification Number (NPI #): _____

D. Do you have your Medicare #: ☐ Yes ☐ No

E. Medicare Number (PIN) _____ UPIN: _____

F. Do you have your Medicaid #: ☐ Yes ☐ No? If yes, please provide _____

G. Do you have your DEA #: ☐ Yes ☐ No? If yes, please provide _____

PRIVILEGES and PANELS

15. Please list all local hospitals at which you currently have privileges.

_____ _____

_____ _____

16. List any HMO's or insurance company with whom you <u>currently</u> contract:

_____ _____

_____ _____

WORK HISTORY (inclusion of resume required)

Name of most recent employer _____

Address of employer _____
Street Address

_____
City State Zip

Salary at departure_____ Name of Immediate Supervisor_____

Dates of employment: From _____ To _____

Duties: _____

_____

Reason for leaving: _____

_____

Name of most recent employer _____

Address of employer _____
Street Address

_____
City State Zip

Salary at departure_____ Name of Immediate Supervisor_____

Dates of employment: From _____ To _____

Duties: _____

_____

Reason for leaving: _____

_____

Name of most recent employer _____

Address of employer _____
Street Address

_____
City State Zip

Salary at departure_____ Name of Immediate Supervisor_____

Dates of employment: From _____ To _____

Duties: _____

_____

Reason for leaving: _____

_____

Name of most recent employer _____

Address of employer _____
Street Address

_____
City State Zip

Salary at departure_____ Name of Immediate Supervisor_____

Dates of employment: From _____ To _____

Duties: _____

_____

Reason for leaving: _____

_____

PROFESSIONAL LIABILITY

Malpractice insurance is required for your employment at NHA. In order to obtain this coverage, we require answers to the following questions. Please circle the appropriate answer and provide an explanation for any "yes" answers. Please use the "additional information" section of this form if additional space is required.

1. Has membership in any professional association or society ever been revoked or refused?

   ☐ Yes ☐ No If yes, explain: _____

2. Has any hospital suspended, restricted or refused you staff privileges?

   ☐ Yes ☐ No If yes, explain: _____

3. Have you ever voluntarily surrendered or had a state license to practice medicine refused, suspended or revoked?

   ☐ Yes ☐ No If yes, explain: _____

4. Are you currently being treated for alcoholism, narcotic addition, or mental illness?

   ☐ Yes ☐ No If yes, explain: _____

5. Have you ever been convicted of a felony?

   ☐ Yes ☐ No If yes, what _____ Explain: _____

   _____

6. Will you require any accommodation to enable you to perform the essential functions of a physician as outlined in the job description?

   ☐ Yes ☐ No

   If so, please describe on detail: _____

   _____

7. Have you ever had any professional liability insurance refused, cancelled or non-renewed?

   ☐ Yes ☐ No If yes, explain: _____

8. Have you ever had a grievance filed against you with your County or State Medical Society?

   ☐ Yes ☐ No If yes, explain: _____

9. Do you render patients unconscious for treatment in your office or other non-hospital facility?

   ☐ Yes ☐ No If yes, explain: _____

10. Please list any litigation past or current in which you are involved. If additional space is required, please use the "additional information" section of this form.

Description: _____

Has a lawsuit been filed? ☐ Yes ☐ No

If so, what attorney is representing you:

Name of Attorney: _____

Address: _____

City, State, Zip: _____

Description: _____

Has a lawsuit been filed? ☐ Yes ☐ No

If so, what attorney is representing you:

Name of Attorney: _____

Address: _____

City, State, Zip: _____

11. If hired, when are you available to begin work? _____

12. Are you seeking full or part-time employment? ☐ Full-time ☐ Part-time

13. Are there any days or times that you are unavailable for work? _____

MISCELLANEOUS INFORMATION

14. If hired, you will be required to present the following **prior to beginning employment with NHA.**

A. Proof of citizenship or legal entry into the USA
B. Proof of graduation from an approved medical, dental, pharmacy, osteopathic or other professional school.
C. Proof of completion of residency program.
D. Proof of Board certification or eligibility
E. DEA Certification

F. CPR/ACLS Certification
G. Ohio State License
H. Certification of Authority for Certified Nurse Practitioners
I. Certification of Prescription Authority for Nurse Practitioners

15. We will request that you sign a release that will allow us to speak freely with your former employer.

16. If hired, and we are unable to reach your references, your employment with NHA may be terminated.

17. Where applicable, the National Practitioner Data Bank will be contacted prior to your employment.

18. In order to adhere to our credentialing policy, we may contact your school of graduation for a certified copy of your degree. Your employment will be terminated if after 90 days of our request, we have not received this copy from the institution. Your employment will be re-instated once the information is received.

SPACE FOR ADDITIONAL INFORMATION

Please list the number of the question which the information applies.

EMPLOYMENT REFERENCES (Please provide professional references only)

Full Name	Address	Position	Telephone

APPLICANT'S AFFIRMATION OF APPLICATION

I hereby certify that answers given herein are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision. This application for employment shall be considered active for a period of time not to exceed 90 days. In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide all rules and regulations of the employer.

The Neighborhood Health Association has a Drug Free Workplace Policy that requires drug testing of all new employees as part of the pre-employment screening process. Applicants will be required to voluntarily submit to a urinalysis at a laboratory chosen by the company. Our policy also states that 10% of all NHA employees will be randomly tested yearly.

_____ _____

Signature of Applicant Date

For Personnel Office Use Only

National Data Bank Information

Date Contacted_____ Information Obtained _____

_____

_____

_____

_____

Signature of Staff Obtaining Information

Reference Check Information

Date Contacted_____Employer_____

Person providing information_____ Position_____

Information Obtained_____

_____

_____

_____

_____

Signature of Staff Obtaining Information

Reference Check Information

Date Contacted_____Employer_____

Person providing information_____ Position_____

Information Obtained_____

_____

_____

_____

_____

Signature of Staff Obtaining Information

Neighborhood Health Association
Employment Application
Consent for the Release of Professional Credential Verifications
For Contract, Licensed, Associates

I hereby authorize and release Neighborhood Health Association, Inc., to independently verify my license(s), DEA permit, hospital privileges, Board certification, and any other professional, medically related information which I have disclosed in my application, my resume, or with the National Data Bank. I understand that any information obtained in this verification process is confidential and may not be released without my written permission.

This authorization is valid for one year (1 year) from the date of signature.

_____ _____

Contract Employee Date

NEIGHBORHOOD HEALTH ASSOCIAITON
PHYSICAL FOR CONTINGENT OFFER OF EMPLOYMENT
EMPLOYMENT HISTORY AND PHYSICAL
(For Physicians, Certified Nurse Practitioners and Dentists Only)

Instructions: The following information is required for the NHA application for coverage under the Federal Government's Tort Claims Act Insurance. All questions are required to be completed in full.

Date_____

1. Name_____ Degree _____

Part I (to be completed by applicant)

2. Do you have any history of the following

   Diabetes: ☐ Yes ☐ No Tuberculosis: ☐ Yes ☐ No Hepatitis: ☐ Yes ☐ No

   Positive skin test for tuberculosis: ☐ Yes ☐ No Do you smoke cigarettes? ☐ Yes ☐ No

   Do you drink alcohol? ☐ Yes ☐ No If yes, amount consumed weekly _____

   Do you have any food or drug allergies? ☐ Yes ☐ No If yes, please list _____

   _____

3. Please list all hospitalizations and include approximate date and reason for hospitalization (including outpatient surgeries).

Date	Reason for Hospitalization/Surgery

4. Please list any medications taken daily.

   _____ _____ _____

   _____ _____ _____

5. List any chronic conditions or illnesses.

   _____ _____ _____

   _____ _____ _____

Applicant's Signature_____

Part II (to be completed by physician)

1. Blood Pressure _____ Pulse _____

2. Visual acuity (corrected) ODU_____/20 OS_____/20

OU _____/20

3. General Appearance _____

_____

4. HEENT _____

5. Heart _____

6. Lungs _____

7. Abdomen (including hernia exam)_____

8. Musculoskeletal (attention to back exam)_____

9. Neurologic _____

10. Rubella Immune Status (riter or evidence of immunization) _____

_____

11. PPD or Tine Test (results/date) _____

12. Hepatitis Vaccine Series (dates) 1._____ 2._____

3._____

IMPRESSION (check one)

Normal Physical Exam _____

The following conditions, chronic illnesses or abnormalities were identified:

A. _____

B. _____

C. _____

_____ _____

Signature of Examining Physician Date