PHYSICIAN ASSISTANT/NURSE PRACTITIONER APPLICATION

This application is submitted to **Emergency Physicians Medical Group (EPMG).**

1. INSTRUCTIONS:

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. **Current copies of the following documents must be submitted with this application:**

- State Medical License(s)
- State Controlled Substance License(s) (if applicable)
- DEA Certificate (if applicable)
- National Certification Certificate
- College Diploma
- ACLS, ATLS, PALS, or APLS Certificate(s)
- Curriculum Vitae – Signed and Dated
- DD214 - Military Discharge Papers (if applicable)

2. IDENTIFYING INFORMATION

Last Name:	First:	Middle:	Degree:
Other name under which you have been known:			
Have you previously been employed with EPMG or Emergency Physicians Medical Group, PC (EPMG)? ☐ Yes ☐ No	If Yes, When? From:	To:	
Home Mailing Address:	City:		
	State:	ZIP:	
Home Telephone Number:	Work Telephone Number:		
Home Fax Number:	Cell Phone Number:		
Email Address:	Pager Number:		
Social Security Number:	Will you be able to provide the necessary documentation establishing that you are legally able to work in the United States for the next year?		
Applying for: ☐ Full-time ☐ Part-time	☐ Yes ☐ No		
Specialty:	Subspecialties:		

3. REFERRAL INFORMATION

How were you referred to EPMG?

☐ Friend (if so, who?) Name: ☐ Contacted by Representative (please specify)

☐ Postcard ☐ Journal Ad ☐ Letter ☐ Newspaper Ad ☐ Website ☐ Convention/Seminar (please specify)

☐ Other (please specify)

4. MILITARY SERVICE

Military Information (if applicable):	From:	To:
Branch:	Discharge Date:	
Present status:	Dishonorable Discharge: ☐ Yes ☐ No	

Clinician Name:_____

5. EDUCATION		
College or University Name:	Degree Received:	Date of graduation: (mm/yy) (for verification purposes only)
Mailing Address:	City:	
	State:	ZIP:
College or University Name:	Degree Received:	Date of graduation: (mm/yy) (for verification purposes only)
Mailing Address:	City:	
	State:	ZIP:
College or University Name:	Degree Received:	Date of graduation: (mm/yy) (for verification purposes only)
Mailing Address:	City:	
	State:	ZIP:

6. NATIONAL CERTIFICATION

Include certifications by board(s) which are duly organized and recognized by:

Name of Issuing Board	Specialty	Date Certified/Recertified:	Expiration Date (if any)

If not certified, are you eligible for the certification exam? ☐Yes ☐No

If Yes, when are you scheduled to take the certification exam? **Please provide copy of letter scheduling exam.**

Other Professional Societies:

7. OTHER CERTIFICATIONS (e.g. BLS, ACLS, ATLS, PALS, APLS (Remember to attach copies of documents.)

Type: Expiration Date:	Type: Expiration Date:
Type: Expiration Date:	Type: Expiration Date:

8. MEDICAL LICENSURE/REGISTRATIONS (Remember to attach copies of documents.)

Current State: Medical License Number: Issue Date: Expiration Date:

Drug Enforcement Administration (DEA) Registration Number: Expiration Date:

Controlled Substances License (if applicable): Expiration Date:

Medicare UPIN/National Provider Identifier (NPI):

9. ALL OTHER STATE MEDICAL LICENSES List all medical licenses now or previously held. (Attach additional sheets if necessary. Reference this Section Number and Title)

State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:

Clinician Name:_____

10. PROFESSIONAL LIABILITY (Attach copy of professional liability policy or certification face sheet)			
Current Insurance Carrier:	Policy Number:		Original effective date:
Mailing Address:	City:		
	State:		ZIP:
Per Claim Amount: $	Aggregate Amount: $		Expiration Date:
Explain any professional liability suits filed against you (open, closed, pending, dismissed, etc.) on the attached <u>separate sheet</u>.			
Please list all of your professional liability carriers within the **past five years**, other than the one listed above:			
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:	City:		
	State:		ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:	City:		
	State:		ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:	City:		
	State:		ZIP:

Clinician Name:____

11. HOSPITAL AND/OR PRACTICE WORK HISTORY (Attach additional sheets if necessary. Reference This Section Number and Title)	
Please list in reverse chronological order all institutions where you have current affiliations and have had previous privileges during the past ten years. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.	
ATTACH EXPLANATION OF ANY TIME GAPS	
Name and Mailing Address:	City: State: ZIP:
Supervisor:	From: (mm/yy) To: (mm/yy)
Name and Mailing Address:	City: State: ZIP:
Supervisor:	From: (mm/yy) To: (mm/yy)
Name and Mailing Address:	City: State: ZIP:
Supervisor:	From: (mm/yy) To: (mm/yy)
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Name and Mailing Address:	City: State: ZIP:

Clinician Name:_____

Supervisor:	From: (mm/yy) To: (mm/yy)
Name and Mailing Address:	City: State: ZIP:
Supervisor:	From: (mm/yy) To: (mm/yy)
Name and Mailing Address:	City: State: ZIP:
Supervisor:	From: (mm/yy) To: (mm/yy)

12. REFERENCES

Please provide the name and complete mailing addresses for three physician supervisors who have knowledge of your current clinical ability, ethical character, health status and ability to work cooperatively with peers. It is important to provide the appropriate reference and complete mailing addresses.

Name:	Specialty:	Telephone Number: Fax:
Mailing Address:	City: State: ZIP:	
Name:	Specialty:	Telephone Number: Fax:
Mailing Address:	City: State: ZIP:	
Name:	Specialty:	Telephone Number: Fax:
Mailing Address:	City: State: ZIP:	

Clinician Name:_____

13. ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no". If your answer to question A is "yes", please provide a copy of the state and/or federal order, if your answer to questions B through N is "yes", please provide full details on a separate sheet.

A. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, investigated, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?

Yes ☐ No ☐

B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?

Yes ☐ No ☐

C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?

Yes ☐ No ☐

D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

Yes ☐ No ☐

E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?

Yes ☐ No ☐

F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?

Yes ☐ No ☐

G. Have you been denied certification/recertification by a specialty board, or has your eligibility, certification, or recertification status changed (other than changing from eligible to certified)?

Yes ☐ No ☐

H. Have you ever been convicted of any crime (other than a minor traffic violation)?

Yes ☐ No ☐

I. Have you ever been convicted of a criminal offense related to the provisions of health care?

Yes ☐ No ☐

J. Are you excluded, debarred, or otherwise ineligible to participate in the Federal Healthcare program or Federal procurement or non-procurement programs?

Yes ☐ No ☐

K. Do you currently use drugs illegally?

Yes ☐ No ☐

L. Have any judgments been entered against you, or settlements been agreed to by you in professional liability cases or are there professional liability lawsuits/arbitrations pending against you?

Yes ☐ No ☐

M. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

Yes ☐ No ☐

N. Is there any reason you may not be able to perform all the services with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients? (The need for an accommodation does not necessarily bar employment. A determination will be made as to the effectiveness with which the accommodation will allow you to perform the essential functions of the position(s) and the hardship it would impose on the employer.)

Yes ☐ No ☐

Clinician Name:_____

A yes response does not automatically disqualify a job applicant from further consideration. Each situation is evaluated relative to the job being sought. Factors such as age and nature of the Offense, and rehabilitation will be taken into account.

I hereby affirm that the information submitted in this Section XIII, Attestation Questions, and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material, omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician assistant/nurse practitioner participation agreement.

Applicant's Signature _____ Date _____

Clinician Name:_____

UNDERSTANDING AND AUTHORIZATION

I certify that information given in the Application and related documentation is true and complete without qualification. I understand that EPMG (the "Company") may investigate my work and professional history and verify all data given on this Application, or related papers, and in interviews, and I authorize the Company to do the same. I consent to the conduct of this inquiry and to the consideration of any statements of references or former employers that are given in response to the inquiry. I authorize all individuals, schools, present and past malpractice carriers, and employers named, to provide information requested about me. I understand and acknowledge that the Company is entitled to rely on the representations made by me in the hiring process, and therefore I understand and acknowledge no matter when a misrepresentation or omission is discovered, that any misrepresentation or omission of fact by me can result in immediate discharge if deemed appropriate in the Company's sole discretion.

I also understand and acknowledge that, to the extent I am employed by the Company in any position, my employment and compensation is and will be at the will of the Company, and can be terminated, with or without cause, and with or without notice, at any time at the option of either the Company or myself. I further understand and agree that no manager, representative, agent or employee of the Company, other than its President, has now or has had in the past any authority to enter into any agreement of employment for any specified period of time, or to make any agreement which is contrary to or a modification of the above described employment relationship, and that any such agreement or representation must be in writing and signed by both myself and the President of the Company, in order for it to be effective.

I further understand and acknowledge that, as part of the hiring process and throughout my employment, if hired, I may be required to submit to medical/physical examinations (which may include tests for drugs and/or alcohol) at the Company's discretion and expense.

Applicant's Signature: _____ Date: _____

PLEASE READ

This application will only be considered for the 120-calendar day period after dated above. Should you wish to be considered after this period, you must reapply.

EPMG is an equal opportunity employer and complies with all laws prohibiting discrimination on the basis of such factors as race, color, age, sex, national origin, religion, citizenship, handicap, height, weight, and marital status. Under the Michigan Handicapper's Civil Rights Act and the federal Americans with Disabilities Act, the employer has legal obligations to accommodate an employee's or job applicant's handicap unless the accommodation would impose an undue hardship on the employer. A handicapper may allege a violation against an employer regarding a failure to accommodate his or her handicap under Michigan law only if the handicapper notifies the employer in writing of the need for accommodation within 182 days after the date the handicapper knew or reasonably should have known that an accommodation was needed.

Clinician Name:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

For the purpose of this authorization, I understand that the term "information" shall include but is not limited to both oral and written information, and shall include all records and documents, including medical records and otherwise privileged or confidential information. The phrase "bearing on my professional competence and qualification" shall mean material which provides an evaluation of my clinical ability, professional ethics, character, physical and mental health, emotional stability and other qualifications for associate health professional staff, medical staff and clinical privileges. The term "third parties" shall include other hospitals, trustees, medical staffs and licensing associations, managed care plans, colleagues, and other organizations or persons concerned with provider and/or practitioner performance and the quality of care.

By applying for employment, affiliation, appointment, reappointment, or credentialing services with EPMG (Emergency Physicians Medical Group) or its clients, I hereby:

1. Authorize each hospital or client of EPMG and their representatives to consult with administrators and members of medical staffs of other hospitals, institutions and with others with whom I have been associated, including past and present malpractice carriers, who may have information bearing on my professional competence and qualifications.
2. Authorize EPMG or its client and their respective representatives to receive and inspect all information bearing on any professional competence and qualifications in accordance with respective hospital medical staff bylaws, rules and regulations.
3. Acknowledge that "credentialing information," includes but is not limited to, all information on applications, references, data and reports which reasonably relates to qualifications, competency, ability to practice, professional ethics and conduct of an applicant, medical staff member, and or participating practitioner. This information may be shared between EPMG, its contracted hospitals and its credentials verification clients.
4. Authorize EPMG, its clients and their respective representatives to query and report to the National Practitioner Data Bank as mandated by Title IV of Public Law 99-660, Health Care Quality Improvement Act of 1986.
5. Release from any and all liability each hospital, EPMG, its clients and their representatives for their acts performed in good faith and without malice in connection with their evaluation of my professional competence and qualifications.
6. Release from any and all liability all third parties, which in good faith and without malice, provide to each hospital, EPMG, its clients and their representatives. Information bearing on my professional competence and qualifications. I consent to the release of such information to each hospital, EPMG, its clients and their representatives and agree to execute general and specific releases upon request of each hospital in accordance with its bylaws.
7. Attest that all information I have provided in this application and its attached documentation is true and complete without qualification.

Applicant's Signature: _____ Dated: _____

Clinician Name:_____

Malpractice Explanation Form

Please complete a separate form for each claim or suit reported.

1. Name, age and sex of patient

2. Date of first consultation

3. Physical condition and diagnosis at above date

4. Dates of treatment given and nature of same

5. Date of claim, and allegations made against you

6. Disposition of claim (settled, non-suit etc.), amount of judgment of settlement

7. What insurance company, if any, was involved?

8. Subsequent condition of health of patient

9. Names of other doctors, if any, involved in the claim or suit

10. To whom may we refer for further information about the suit?

{ [illegible] _____ 5[illegible] Completed _____