



Advanced Practice Application
Primary Specialty: o CRNA o NP o PA

Identifying Information

Last Name First Name Middle Name Social Security No.

Current Address: Street Address City State/Province Zip/Postal Code Country

Permanent Address (if different) Street Address City State/Province Zip/Postal Code Country

Home Phone: Work Phone: Cell Phone:

Email Address: Best time/day to reach you:

Other names you have been employed under:

Secondary Specialty: NPI (if applicable)

Date Available to work:

Name of Emergency Contact: Relationship: Phone:

Street Address City State/Province Zip/Postal Code Country

Are you a U.S. citizen? o Yes o No If no, can you submit verification of your legal right to work in the U.S. o Yes o No

Undergraduate Education

School Name/Institution

City State Date of Graduation

Degree/Certifications Honors Received

Professional Training/Education

School Name/Institution

City State Date of Graduation

Degree/Certifications Honors Received

Other Education

School Name/Institution

City State Date of Graduation

Degree/Certifications Honors Received

**Professional License & Certification Information**

**Licensure** (Include photocopies of licenses held)

State: \_\_\_\_\_ License # \_\_\_\_\_ Date Issued: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ CSP # \_\_\_\_\_ Exp. Date: \_\_\_\_\_  
State: \_\_\_\_\_ License # \_\_\_\_\_ Date Issued: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ CSP # \_\_\_\_\_ Exp. Date: \_\_\_\_\_  
State: \_\_\_\_\_ License # \_\_\_\_\_ Date Issued: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ CSP # \_\_\_\_\_ Exp. Date: \_\_\_\_\_  
State: \_\_\_\_\_ License # \_\_\_\_\_ Date Issued: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ CSP # \_\_\_\_\_ Exp. Date: \_\_\_\_\_

**Professional Certifications** (Include photocopies of certifications held)

Certification Board: \_\_\_\_\_ Certification Board: \_\_\_\_\_  
Date Certified: \_\_\_\_\_ Date Certified: \_\_\_\_\_  
Date Certified: \_\_\_\_\_ Date Certified: \_\_\_\_\_  
Recertification Date: \_\_\_\_\_ Recertification Date: \_\_\_\_\_

**National Certifications** (Include photocopies of certifications held)

Name Certifying Organization: \_\_\_\_\_ Name of Certifying Organization: \_\_\_\_\_  
Date Certified: \_\_\_\_\_ Date Certified: \_\_\_\_\_  
Recertified?  Yes  No Date: \_\_\_\_\_ Recertified?  Yes  No Date: \_\_\_\_\_

**DEA Registration:**  Yes  No

Registration # \_\_\_\_\_ Date Issued: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

**Affiliations/Memberships in Professional Organizations**

Organization: \_\_\_\_\_  
Dates of Membership (from – to): \_\_\_\_\_

Organization: \_\_\_\_\_  
Dates of Membership (from – to): \_\_\_\_\_

**Employment History**

Please list all of your employment for the past ten (10) years beginning with your most recent employer. Please list each facility in which you have worked.

Are you currently employed now?  Yes  No If so, may we contact your present employer?  Yes  No

Facility/Employer Name: \_\_\_\_\_ Unit/Floor/Dept: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

Dates Employed: From \_\_\_\_\_ to \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

Position Held: \_\_\_\_\_ Discipline: \_\_\_\_\_ Unit Specialty: \_\_\_\_\_

Travel Assignment?  Yes  No Travel Company: \_\_\_\_\_ Local Staff Agency?  Yes  No

**Employment History Continued**

Facility/Employer Name: \_\_\_\_\_ Unit/Floor/Dept: \_\_\_\_\_  
 City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_  
 Dates Employed: From \_\_\_\_\_ to \_\_\_\_\_ Reason for leaving: \_\_\_\_\_  
 Position Held: \_\_\_\_\_ Discipline: \_\_\_\_\_ Unit Specialty: \_\_\_\_\_  
 Travel Assignment?  Yes  No Travel Company: \_\_\_\_\_ Local Staff Agency?  Yes  No

Facility/Employer Name: \_\_\_\_\_ Unit/Floor/Dept: \_\_\_\_\_  
 City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_  
 Dates Employed: From \_\_\_\_\_ to \_\_\_\_\_ Reason for leaving: \_\_\_\_\_  
 Position Held: \_\_\_\_\_ Discipline: \_\_\_\_\_ Unit Specialty: \_\_\_\_\_  
 Travel Assignment?  Yes  No Travel Company: \_\_\_\_\_ Local Staff Agency?  Yes  No

Facility/Employer Name: \_\_\_\_\_ Unit/Floor/Dept: \_\_\_\_\_  
 City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_  
 Dates Employed: From \_\_\_\_\_ to \_\_\_\_\_ Reason for leaving: \_\_\_\_\_  
 Position Held: \_\_\_\_\_ Discipline: \_\_\_\_\_ Unit Specialty: \_\_\_\_\_  
 Travel Assignment?  Yes  No Travel Company: \_\_\_\_\_ Local Staff Agency?  Yes  No

Facility/Employer Name: \_\_\_\_\_ Unit/Floor/Dept: \_\_\_\_\_  
 City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_  
 Dates Employed: From \_\_\_\_\_ to \_\_\_\_\_ Reason for leaving: \_\_\_\_\_  
 Position Held: \_\_\_\_\_ Discipline: \_\_\_\_\_ Unit Specialty: \_\_\_\_\_  
 Travel Assignment?  Yes  No Travel Company: \_\_\_\_\_ Local Staff Agency?  Yes  No

**Disciplinary Actions**

Have any of the following ever been or are currently in the process of being investigated, denied, revoked, suspended, reduced, limited, placed on probation, not renewed, been subject to disciplinary action or voluntarily relinquished? If yes, please provide detailed explanation.

Medical License in any state/jurisdiction? <input type="radio"/> Yes <input type="radio"/> No	DEA Registration? <input type="radio"/> Yes <input type="radio"/> No
Other Professional Registration/License? <input type="radio"/> Yes <input type="radio"/> No	Clinical Privileges? <input type="radio"/> Yes <input type="radio"/> No
Membership/Rights on any Medical Staff? <input type="radio"/> Yes <input type="radio"/> No	Institutional Affiliation/Status? <input type="radio"/> Yes <input type="radio"/> No

Have you ever been convicted of a felony or misdemeanor?  Yes  No

Have there ever been or are there currently pending, any malpractice claims, suits, settlements, or arbitration proceedings involving your professional practice?  Yes  No

Have you ever been denied, gone without, or not maintained Professional Liability Insurance?  Yes  No

Do you currently have any medical condition or use any chemical substance which impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, provide evidence that such conditions do not currently impair or limit your ability to practice medicine in your specialty with reasonable skill and safety.  Yes  No

Within the past two (2) years, have you received treatment for alcoholism, drug abuse, or for any infectious disease, mental illness, or psychiatric problem which could impair or limit your ability to practice medicine in your specialty with reasonable skill and safety? If yes, provide evidence that such conditions do not currently impair or limit your ability to practice medicine in your specialty with reasonable skill and safety.  Yes  No

Other than those circumstances noted above, is there anything in your personal or professional background that may surface during our credentials verification process that may be construed as derogatory or negative?  Yes  No

Please list a minimum of three professional references with whom you have worked in the past two years and who will confirm a more detailed reference of your specific medical abilities.

<b>1. Name &amp; Facility</b>	<b>Position</b>	<b>Association</b>	<b>Phone</b> ( )
<b>Specialty</b>	<b>City, State</b>	<b>Zip</b>	<b>Email address</b>
<b>2. Name &amp; Facility</b>	<b>Position</b>	<b>Association</b>	<b>Phone</b> ( )
<b>Specialty</b>	<b>City, State</b>	<b>Zip</b>	<b>Email address</b>
<b>3. Name &amp; Facility</b>	<b>Position</b>	<b>Association</b>	<b>Phone</b> ( )
<b>Specialty</b>	<b>City, State</b>	<b>Zip</b>	<b>Email address</b>
<b>4. Name &amp; Facility</b>	<b>Position</b>	<b>Association</b>	<b>Phone</b> ( )
<b>Specialty</b>	<b>City, State</b>	<b>Zip</b>	<b>Email address</b>

By signing/electronically signing below, I attest that all statements in this application are true and accurate to the best of my knowledge. I understand that any falsification could lead to disciplinary action and/or termination of employment. I authorize Next Medical Staffing to contact past employers and references in order to verify the information I have provided. I release all such persons from liability for furnishing said information. I authorize Next Medical Staffing to release a copy of this application and any supporting information (medical references, background search results, etc.) which may be relevant to my employment to their client facilities.

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Applicant Name and Title (print)**