



Physician Application
Degree: o MD o MBBS o Other

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:

Discipline: Other/Secondary Discipline:

Current Specialty: Other/Secondary Specialty:

Date Available to work: NPI #:

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

Professional License & Certification Information

Licensure (Include photocopies of licenses held)

State: License # Date Issued: Exp. Date: Controlled Substance Permit #
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Professional Certifications (Include photocopies of certifications held)

Certification Board: Date Certified: Recertification Date:
Certification Board: Date Certified: Recertification Date:

Clinical Certifications (Include photocopies of certifications held)

BLS Certification: o Yes o No Expiration Date: ACLS Certification: o Yes o No Expiration Date:
ATLS Certification: o Yes o No Expiration Date: PALS Certification: o Yes o No Expiration Date:

DEA Registration: o Yes o No

Registration # Date Issued: Exp. Date:
Registration # Date Issued: Exp. Date:
Registration # Date Issued: Exp. Date:

If you do not currently possess a DEA Registration, please explain:

Pre-Medical Education

School Name/Institution _____
City _____ State _____ Date of Graduation _____
Degree/Certifications _____ Honors Received _____

Medical Education

School Name/Institution _____
City _____ State _____ Date of Graduation _____
Degree/Certifications _____ Honors Received _____

Internship

Type: _____ Institution: _____
City _____ State _____ Dates Attended (from) _____
(to) _____ Program Director _____

Residency

Type: _____ Institution: _____
City _____ State _____ Dates Attended (from) _____
(to) _____ Program Director _____

Additional Residency or Fellowship

Type: _____ Institution: _____
City _____ State _____ Dates Attended (from) _____
(to) _____ Program Director _____

Affiliations

Facility/Practice: _____ Dates (From) _____ (To) _____
Street: _____ City: _____ State: _____ Zip/Postal Code: _____ Capacity _____

Facility/Practice: _____ Dates (From) _____ (To) _____
Street: _____ City: _____ State: _____ Zip/Postal Code: _____ Capacity _____

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

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 signed and dated explanation on a separate sheet.

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
Any Professional Sanction? <input type="radio"/> Yes <input type="radio"/> No	
Professional Society Membership or Fellowship/Board Certification?	<input type="radio"/> Yes <input type="radio"/> No
Participation in any Private, Federal or State Health Insurance Program?	<input type="radio"/> Yes <input type="radio"/> No

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

Have you ever had a license or certification investigated, suspended, or revoked? 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.

1. Name & Facility	Position	Association	Phone ()
Specialty	City, State	Zip	Email address
2. Name & Facility	Position	Association	Phone ()
Specialty	City, State	Zip	Email address
3. Name & Facility	Position	Association	Phone ()
Specialty	City, State	Zip	Email address
4. Name & Facility	Position	Association	Phone ()
Specialty	City, State	Zip	Email address

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

Applicant Name and Title (print)

Date