



CONTRACTOR RECREDENTIALING APPLICATION

Print Name: _____

Please return all requested documents to:

ATT: _____
Recruiter's Name

Jackson & Coker
3000 Old Alabama Road
Suite 119-608
Alpharetta, GA 30022
800.272.2707 toll free
800.936.4562 fax

Photo / Identification Required:

**ATTACH CURRENT PHOTO HERE.
INDICATE DATE TAKEN
AND SIGN IN INK ACROSS THE BOTTOM
OF PHOTO.**

Note: Photo must be:

1. Original
2. No larger than 3 by 4 inches
3. Taken within one year of application
4. Close-up view of self – not profile
5. Instant Polaroid photographs not acceptable

Your Signature Across the Bottom and Date



Physician ReCredentialing Checklist

- _____ Completed Credentialing Application
- _____ Signed and Currently Dated Attestation and Release forms
- _____ Completed W-9 Federal Tax Form
- _____ Completed Authorization for Direct Deposit Form
- _____ Current Curriculum Vitae with complete Professional History in chronological order and no gaps
(month and year must be included)
- _____ Current CME (CME activity for the past two years)
- _____ Copy of all current active state license wallet card(s) with expiration date and number; if not available, copy of wall certificate
- _____ Copy of current Federal DEA and current State Controlled Substance Registrations or certificate(s)
- _____ Copy of Any: BLS, ACLS, ATLS, PALS, APLS, NRP Certificate(s)
- _____ Certificate of Professional Liability Insurance Coverage or Declaration Page (Face Sheet) of Policy (if applicable)
- _____ Third party documentation (i.e. court documents, dismissals) for all Malpractice/Disciplinary Actions OR completion of appropriate Explanation Form attached (if applicable)
- _____ Permanent Resident Card, Green Card or Visa Status (if applicable) ***All non US citizens must provide copy of green card***
- _____ Military Discharge Record -Form DD-214 (if discharged within past two years)
- _____ 3 Written Letters of Recommendation from providers who have directly observed you in practice within the past year (They must assess your clinical competence and specify the date they last observed you in practice-month/year)
- _____ Completed Delineation of Privileges Form
- _____ Recent Photograph Signed and Dated in the margin
- _____ Copy of current Drivers License or Passport
- _____ Copies of current Immunization records and most recent TB test results (if available)
- _____ Completed Locum Tenens Practice Experience Form (If Applicable)
- _____ Case logs from last 24 months (If Applicable)
- _____ Mammo #s and MQSA (If Applicable)



Physician ReCredentialing Application

Personal Information	Last Name	Suffix (Jr. Sr. III)	First Name	Middle	Degree	Social Security Number	
	Home Address					Home Phone Number	
	City		State		Zip code	Cell Phone Number	
	Office Address					Office Phone Number	
	City		State		Zip code	Email Address	

Board Certification/Recertification

Are you currently board certified? Yes <input type="checkbox"/> No <input type="checkbox"/> List all current and past board certifications					
Name of issuing board	Specialty	Date Certified (mm/yy):	Date Recertified (mm/yy):	Date Recertified (mm/yy):	Expiration Date(if any)(mm/yy):
		/	/	/	/
		/	/	/	/
Clinical Certification	BLS Certification: Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration Date: _____	ACLS Certification: Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration Date: _____	ATLS Certification: Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration Date: _____	PALS Certification: Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration Date: _____	
Federal Provider Information		Federal DEA Number:			DEA Expiration Date: /

LICENSURE

Please enter the information in the table below for all states in which you have held a medical license.

STATE	LICENSE NUMBER	LICENSE STATUS	DATE LICENSE GRANTED (MM/YY)	LICENSE EXPIRATION DATE (MM/DD/YY)	STATE MEDICARE PROVIDER NUMBER	STATE MEDICAID PROVIDER NUMBER	STATE CONTROLLED SUBSTANCE PERMIT NUMBER
		Initial License <input type="checkbox"/> <input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					

Additional licenses listed on attached sheet



Print Name: _____

REFERENCES

Please list four **physician** references that are able to comment upon your **current (within the past year)** clinical and professional capabilities.

Name	Specialty	Phone #
Address	City State Zip code	Fax #
		Email
Name	Specialty	Phone #
Address	City State Zip code	Fax #
		Email
Name	Specialty	Phone #
Address	City State Zip code	Fax #
		Email
Name	Specialty	Phone #
Address	City State Zip code	Fax #
		Email

WORK HISTORY

Please list all your practice locations and employment affiliations to cover at least the last two years of clinical practice, since the date of your last application. **Beginning and ending month are required for each listing.** Please provide a separate explanation of work gaps over 30 days in duration.

From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact <input type="checkbox"/>		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact <input type="checkbox"/>		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact <input type="checkbox"/>		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact <input type="checkbox"/>		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact <input type="checkbox"/>		Address	City	State	Zip Code



PRINT NAME: _____

CURRENT HOSPITAL AFFILIATIONS AND LOCUMS EXPERIENCE

Please list in reverse chronological order with the current affiliation(s) first: Include affiliations for the last 2 years, since the date of your last application. Do not list residencies, internships or fellowships.

NO CURRENT OR PREVIOUS AFFILIATIONS HELD - Does not apply

Primary Facility Name: Phone: _____ Fax: _____	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Facility Name: Phone: _____ Fax: _____	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Facility Name: Phone: _____ Fax: _____	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Facility Name: Phone: _____ Fax: _____	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Facility Name: Phone: _____ Fax: _____	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Facility Name: Phone: _____ Fax: _____	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Facility Name: Phone: _____ Fax: _____	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Facility Name: Phone: _____ Fax: _____	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Facility Name: Phone: _____ Fax: _____	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Facility Name: Phone: _____ Fax: _____	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Facility Name: Phone: _____ Fax: _____	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Facility Name: Phone: _____ Fax: _____	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Facility Name: Phone: _____ Fax: _____	Appointment Period (mm/yy) From: _____ To: _____	City, State:

PROFESSIONAL LIABILITY INSURANCE

Please list your current malpractice insurance carrier and the associated information for the last 2 years, since the date of your last application. If you currently do not carry any malpractice insurance, please list the last malpractice insurance carrier which provided coverage for you. In addition, please list any malpractice insurance carrier who has been associated with any malpractice claim, suit or settlement below.

Malpractice Insurance Carrier	Policy Number	Policy Dates From (mm/yy)	Policy Dates To (mm/yy)	Amount of Coverage



Print Name: _____

DISCIPLINARY ACTIONS

<p>If your answer to any of the following questions is "Yes", please provide a full explanation and include any additional documentation if necessary.</p> <p>Since the date of your last application, have any of the following ever been, or are currently in the process of, being: denied, revoked, suspended, reduced, limited, placed on probation, not renewed, surrendered or voluntarily relinquished? If the answer is "Yes" to any item please provide an explanation as outlined above.</p>	
1. Medical License in any state? <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Institutional affiliation / status? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. DEA Registration (federal or state programs)? <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Professional society membership or fellowship / Board certification? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Other Professional Registration / License? <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Any professional sanction (e.g. government, administrative agency or other)? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Clinical Privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No	9. Participation in any private, federal, or state health insurance program (e.g. Medicare, Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Membership / Rights on any medical staff? <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Do you currently have any physical or mental condition including current alcohol or drug dependency that may affect your ability to practice or exercise the privileges typically associated with the specialty and position for which you are applying? <input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Are you currently using illegal drugs or legal drugs in an illegal manner? <input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Is there any reason that you are unable to perform the essential functions of the position for which you are applying safely and according to accepted standards of performance with or without reasonable accommodation? (If yes, explain on the attached form) <input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Have you ever been convicted of, pled guilty to, or pled nolo contendere for, any criminal offense (excluding parking tickets)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Are any criminal charges currently pending against you in any jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Have you ever been arrested for or charged with a crime involving children? <input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Have you ever been arrested for or charged with a sexual offense including sexual harassment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
17. Have you ever been arrested for or charged with a crime involving moral turpitude? <input type="checkbox"/> Yes <input type="checkbox"/> No	
18. Is there any other issue which should be disclosed that may have an adverse impact on your ability to deliver effective clinical health care services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
19. Has any information pertaining to you ever been reported to the National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protections Data Bank (HIPDB)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

MALPRACTICE CLAIMS HISTORY

<p>1. Have you ever been denied professional liability insurance or denied renewal of an existing policy? If the answer to the above question is "YES" please attach a brief explanation. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. Have any malpractice claims, suits, settlements, or arbitration proceedings ever been made against you including any that have been dismissed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>3. Are you aware of any claims, suits, or settlements currently pending or of any intent to file a claim or suit? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

If your answer to either of the above questions is "Yes" please provide the following information on each claim and provide a brief clinical summary of each case.



Authorization, Attestation and Release

I acknowledge that Jackson & Coker LocumTenens, LLC (“J&C”) will provide (i) certain services in the furtherance of one or more applications to state medical boards or other designated bodies (“Boards”) to secure for me a license to practice medicine in one or more states (“License Applications” and, together with any credentialing applications, the “Applications”) and (ii) certain credentialing services from time to time on an on-going basis in connection with my candidacy for locum tenens or full-time placement with hospitals, clinics or other healthcare clients (each a “Client”). I understand that, as part of both processes, J&C must collect Information (defined below) from me and from third parties and share all or part of that Information. “Information” includes, but is not limited to, otherwise privileged or confidential information concerning my professional qualifications, credentials, current licensure, education, training, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnoses and treatment, ethics, behavior, or any other matter having a bearing on my qualifications for a license to practice medicine or for credentialing with J&C and the Clients (whether it has such a bearing may be presumed by such third parties solely by receipt of a request of Information from an Agent).

I further acknowledge and understand that my cooperation in providing and assisting J&C in obtaining my Information and my consent to the release of Information does not guarantee that any state will grant me a license to practice medicine or that a Client will grant me clinical privileges or contract with me as a provider of healthcare services. I understand that my credentialing application is not an application for employment and that acceptance of my application will not in itself result in my employment.

Agreement to Provide Information

I agree to provide on a timely basis sufficient and accurate accounts of my Information as deemed necessary or appropriate by J&C for the completion, submittal and support of one or more of my Applications.

Authorization of Investigation Concerning Application

I authorize J&C and its Clients, and their respective employees, affiliated entities and representatives and agents (together and individually the “Agents”), to collect, hold, and investigate both oral and written statements, records, and documents containing my Information, concerning or to be included in any of my Applications. I agree to allow the Agents to inspect and copy all records and documents relating to any Application and to disclose any such Information to a Client, any Board and other appropriate third parties and to share any such Information among themselves in connection with their investigations.

Authorization of Third-Party Sources to Release Information

I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, promptly upon an Agent's request to release Information to the Agent(s). I authorize my current and past professional liability carrier(s) to release to Agents my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide Information based upon this Authorization, Attestation and Release.

Release from Liability

I release from all liability and hold harmless the Agents, any entity responding to a request for Information by an Agent as authorized hereunder and any other third party, and their respective owners, managers, directors, officers, employees, agents and representatives, for their acts performed in good faith and without malice, unless such acts are due to the gross negligence or willful misconduct of such Agent or other third party, in connection with the gathering, holding, use, sharing and interpretation of, and reliance upon, Information. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for credentialing activities.

Attestation

I certify that all Information provided by me in connection with the Applications is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify J&C (and its Client, if requested) within 10 days of any material changes to the Information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided or authorized to be released to Agents in connection with the Applications.

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

APPLICANT'S SIGNATURE: _____ **DATE:** _____

Print Name: _____