CONTRACTOR INITIAL 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 Initial Credentialing 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)

_____ Copy of Medical School Diploma and Training Certificate(s), Internship, Residency and Fellowship Certificates

_____ Current CME (CME activity for the past three years)

_____ Copy of ECFMG Certificate (if applicable) or Fifth Pathway Certificate (if applicable)

_____ Copy of NBME, FLEX, USMLE, or SPEX Scores

_____ Copy of Current Board Certificate

_____ 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 applicable)

_____ 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)

_____Copy of National Provider Identifier (NPI#) documentation and Confirmation Letter

_____Completed Locum Tenens Practice Experience Form (If Applicable)

_____Case logs from last 24 months (If Applicable)

_____ Mammo #s and MQSA (If Applicable)

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Physician Initial Credentialing Application

<table>
<tr><td rowspan="9">Personal Information</td><td colspan="3">Last Name Suffix (Jr. Sr. III) First Name Middle</td><td>Degree</td><td>Social Security Number</td></tr>
<tr><td colspan="4">Home Address</td><td>Home Phone Number</td></tr>
<tr><td colspan="4">City State Zip code</td><td>Cell Phone Number</td></tr>
<tr><td colspan="4">Office Address</td><td>Office Phone Number</td></tr>
<tr><td colspan="4">City State Zip code</td><td>Office Fax Number</td></tr>
<tr><td>Citizenship</td><td>Birthplace</td><td colspan="2">Date of Birth</td><td>Email address</td></tr>
<tr><td colspan="2">Visa Status</td><td colspan="2">NPI #</td><td>Medicare #</td></tr>
<tr><td colspan="2">UPIN #</td><td colspan="2">Fed Tax ID</td><td>Medicaid #</td></tr>
<tr><td colspan="2">Please provide the name and address of someone who will always know your forwarding address</td><td colspan="2">Contact Name and Phone</td><td>Contact Address</td></tr>
<tr><td rowspan="11">Education And Training</td><td colspan="4">Medical School</td><td>Degree</td></tr>
<tr><td colspan="2">Dates (From mm/yy To mm/yy)</td><td colspan="3">City State</td></tr>
<tr><td colspan="3">PGY1 (Internship) Training -- Facility Name</td><td colspan="2">City State</td></tr>
<tr><td colspan="2">Dates (From mm/yy To mm/yy)</td><td colspan="3">Category of Training</td></tr>
<tr><td colspan="3">Residency Training -- Facility Name</td><td colspan="2">City State</td></tr>
<tr><td colspan="2">Dates (From mm/yy To mm/yy)</td><td colspan="3">Specialty</td></tr>
<tr><td colspan="3">Fellowship Training -- Facility Name</td><td colspan="2">City State</td></tr>
<tr><td colspan="2">Dates (From mm/yy To mm/yy)</td><td colspan="3">Specialty</td></tr>
<tr><td colspan="3">Additional Training -- Facility Name</td><td colspan="2">City State</td></tr>
<tr><td colspan="2">Dates (From mm/yy To mm/yy)</td><td colspan="3">Category of Training</td></tr>
</table>

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Print Name: ___________________

Board Certification/Recertification

Are you currently board certified? Yes ☐ No ☐ 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):
		/	/	/	/
		/	/	/	/

Please answer the following questions. Attach explanation form(s) if necessary.

A.	Have you ever been examined by any specialty board, but failed to pass? If yes, please provide name of board(s) and date(s):	Yes ☐ No ☐
B.	1. If you are not currently certified, have you applied for the certification examination? If yes, please provide date you will sit for exam.	Yes ☐ No ☐

Clinical Certification	BLS Certification: Yes ☐ No ☐ Expiration Date: __________	ACLS Certification: Yes ☐ No ☐ Expiration Date: ___________	ATLS Certification: Yes ☐ No ☐ Expiration Date: ___________	PALS Certification: Yes ☐ No ☐ Expiration Date: ___________

Federal Provider Information	Federal DEA Number:	DEA Expiration Date: /

Foreign Graduates	Do you have a permanent ECFMG Certificate? Yes ☐ No ☐	ECFMG Certificate #:	Did you do a fifth Pathway? Yes ☐ No ☐ If so, where?

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 ☐ ☐Active ☐Inactive					
		☐Active ☐Inactive					
		☐Active ☐Inactive					
		☐Active ☐Inactive					
		☐Active ☐Inactive					
		☐Active ☐Inactive					
		☐Active ☐Inactive					
		☐Active ☐Inactive					

☐ ***Additional licenses listed on attached sheet***

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

WORK HISTORY

Please list all your practice locations and employment affiliations to cover at least the past ten years of clinical practice. ***Beginning and ending month and year are required for each listing.*** Please provide a separate explanation of work gaps over 30 days in duration. If you desire Jackson & Coker not to contact these facilities, please check the appropriate box and attach a letter of explanation. You may attach an additional sheet if all required work history information will not fit in this section.

From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact ☐		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact ☐		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact ☐		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact ☐		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact ☐		Address	City	State	Zip Code

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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 10 years. Do not list residencies, internships or fellowships. You may attach an additional sheet if needed.

Current Hospital And Other Facility Affiliations Does not apply ☐

Facility	Appointment Period	City, State
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:

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Print Name: ____________________

DISCIPLINARY ACTIONS

If your answer to any of the following questions is "Yes", please provide a full explanation Credentialing and include any additional documentation if necessary.

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.

1. Medical License in any state? ☐ Yes ☐ No	6. Institutional affiliation / status? ☐ Yes ☐ No
2. DEA Registration (federal or state programs)? ☐ Yes ☐ No	7. Professional society membership or fellowship / Board certification? ☐ Yes ☐ No
3. Other Professional Registration / License? ☐ Yes ☐ No	8. Any professional sanction (e.g. government, administrative agency or other)? ☐ Yes ☐ No
4. Clinical Privileges? ☐ Yes ☐ No 5. Membership / Rights on any medical staff? ☐ Yes ☐ No	9. Participation in any private, federal, or state health insurance program (e.g. Medicare, Medicaid)? ☐ Yes ☐ 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? ☐ Yes ☐ No

11. Are you currently using illegal drugs or legal drugs in an illegal manner? ☐ Yes ☐ 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) ☐ Yes ☐ No

13. Have you ever been convicted of, pled guilty to, or pled nolo contendere for, any criminal offense (excluding parking tickets)? ☐ Yes ☐ No

14. Are any criminal charges currently pending against you in any jurisdiction? ☐ Yes ☐ No

15. Have you ever been arrested for or charged with a crime involving children? ☐ Yes ☐ No

16. Have you ever been arrested for or charged with a sexual offense including sexual harassment? ☐ Yes ☐ No

17. Have you ever been arrested for or charged with a crime involving moral turpitude? ☐ Yes ☐ 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? ☐ Yes ☐ 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)? ☐ Yes ☐ No

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MALPRACTICE CLAIMS HISTORY

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.

☐ Yes ☐ No

2. Have any malpractice claims, suits, settlements, or arbitration proceedings ever been made against you including any that have been dismissed?

☐ Yes ☐ No

3. Are you aware of any claims, suits, or settlements currently pending or of any intent to file a claim or suit?

☐ Yes ☐ No

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.

	Plaintiff Name and Insurance Carrier	Location (County, State)	Status (Dismissed / Settled / Judgment / Pending)	Date of Incident (mm/yy)	Amount of Award or Settlement (if appropriate)
# 1					Summary Included ☐
# 2					Summary Included ☐
# 3					Summary Included ☐
# 4					Summary Included ☐

☐ Additional Malpractice Claims or incidents are listed on attached sheet

Please list your current malpractice insurance carrier and the associated information for the last 10 years. 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 listed below.

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

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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: ____

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