

PHYSICIAN APPLICATION

IDENTIFYING INFORMATION *Please type or print in black ink.*

Last Name		First Name		Middle	Work Phone
Home Address		City	State	Zip	Home Phone
Date of Birth	Place of Birth (City/State/Country)		E-mail address		Cell Phone
Social Security #	National Physician Identifier (NPI #)	Can you provide proof of legal eligibility to work in the USA?	Marital Status (Optional)	Spouse's Name (Optional)	# of Children (Optional)

PRE-MEDICAL EDUCATION *Please list all institutions attended, using a separate sheet if necessary.*

School of Graduation	City	State
Dates Attended Mo/Yr (from) (to)	Degree	

MEDICAL EDUCATION

School of Graduation	City	State
Dates Attended Mo/Yr (from) (to)	Degree	

***If you attended any medical school **other than from which you graduated** list institution name and inclusive dates of attendance:

_____ From(Mo/Yr) _____ To (Mo/Yr) _____

INTERNSHIP

Type	Institution	City	State
Dates Attended Mo/Yr (from) (to)	Program Director		

RESIDENCY

Type	Institution	City	State
Dates Attended Mo/Yr (from) (to)	Program Director		

ADDITIONAL RESIDENCY OR FELLOWSHIP OR OTHER GRADUATE EDUCATION

Type	Institution	City	State
Dates Attended Mo/Yr (from) (to)	Program Director		

AFFILIATIONS

List all present and previous affiliations with health care facilities and medical staff memberships for the past 10 years, in chronological order. Include assistantships, appointments, and military experience. Specify all departments in which privileges were exercised and the nature and extent of such privileges. Use additional page or attach curriculum vitae if needed.

Facility or Practice	Dates Mo/Yr (from) (to)			
Street	City	State	Zip	Capacity
Facility or Practice	Dates Mo/Yr (from) (to)			
Street	City	State	Zip	Capacity
Facility or Practice	Dates Mo/Yr (from) (to)			
Street	City	State	Zip	Capacity

CERTIFICATIONS

Current Specialty Board status:	American Board of:	Certification/Recertification Date (Mo/Yr):	Other Current ABMS/Subspecialty Certification:			
BCLS Exp. Date	ACLS Exp. Date	ATLS Exp. Date	PALS Exp. Date	NRP/NALS Exp. Date	ALSO Exp. Date	MQSA Exp. Date

LICENSURE

What was your original licensing exam? (USMLE, NBME/NBOME, FLEX, COMLEX, or State Exam)	# times taken each step	Exam date(s) each step	State(s) in which you took your exam?	FCVS (Federation Credentials Verification) Profile #-if applicable
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MSI Medical Solutions does not discriminate on the basis of race, religion, national origin, color, sex, age or handicap

Please list ALL medical licenses, active or inactive.

State	Number	Date Issued	Expiration Date	State Controlled Substance #
State	Number	Date Issued	Expiration Date	State Controlled Substance #
State	Number	Date Issued	Expiration Date	State Controlled Substance #
DEA Registration Number		Date Issued	Expiration Date	Schedules
Please list any additional active licenses, with numbers				
In which state did you obtain your original license?				
Please list all additional inactive licenses, with numbers				

In addition to English, other languages spoken with communication ease and/or fluency _____

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING, PLEASE PROVIDE SIGNED and DATED EXPLANATION(S) ON A SEPARATE SHEET

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 full explanation on a separate sheet.**

Medical license in any jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prerogatives/rights on any medical staff?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other professional registration/license?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any medical organization or other institutional affiliation or status there at?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
DEA registration?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Professional society membership or fellowship/Board Certification	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Academic appointment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Professional office?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Membership on any hospital medical staff?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any other type of professional sanction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clinical privileges?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been convicted of a misdemeanor (other than minor traffic violation) or a felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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

REFERENCES Please list a minimum of six (6) professional references with whom you have worked in the past two years and who can attest to your specific medical abilities

1. Name	Association	
Specialty	Home Phone ()	Work Phone ()
2. Name	Association	
Specialty	Home Phone ()	Work Phone ()
3. Name	Association	
Specialty	Home Phone ()	Work Phone ()
4. Name	Association	
Specialty	Home Phone ()	Work Phone ()
5. Name	Association	
Specialty	Home Phone ()	Work Phone ()
6. Name	Association	
Specialty	Home Phone ()	Work Phone ()

I certify that the information on this application is true to the best of my knowledge. I authorize all persons and institutions to disclose to and share with MSI opinions and information regarding me, including but not limited to, information contained in this application and my skills, experience, fitness to practice medicine, character, work habits, and performance. I authorize MSI to release information contained in this application or obtained by MSI pursuant to the authorization contained in this paragraph to MSI's insurance companies and medical facility clients. I waive any claims I might otherwise have against MSI resulting from MSI obtaining or releasing information as authorized by this paragraph.

PRINT NAME

SIGNATURE

DATE