LOCUMCARE

PHYSICIAN
INITIAL CREDENTIALING
APPLICATION

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General Instructions

All information requested in this application is necessary to complete the credentialing process. This information is based on the standards for credentialing established by the National Committee for Quality Assurance (NCQA) and The Joint Commission (TJC). ***Failure to provide the specific requested information will result in delay in verification and approval of your credentialing file.***

- Type or print legibly your responses.
- Note that modification to the wording or format of this application or agreement will invalidate it.
- All questions must be answered fully and truthfully. If an answer requires an explanation, please provide it on the appropriate form provided. Make additional copies of any of the attached forms if more than one is needed and provide your name on all attachments. You may also submit narratives and/or other documentation to support your answers.
- Note that month/years are required for the education and work history sections of the application. All time periods during your clinical career must be accounted for.
- Any gap of time greater than sixty (60) days requires explanation. Please use the enclosed explanation form to provide this information.
- Please do not leave any blanks. If a particular section does not apply to you, write “n/a” in that section.
- A response of “See CV” is *not* acceptable unless you also submit a current CV containing all of the requested information.
- Any changes to your responses must be lined through and initialed. Use of any form of correctional fluid or tape is not acceptable.
- Please sign and provide a current date on the attestation and release pages of the application, the provider agreement, and any other forms completed.
- After the application has been completed in its entirety, make a copy of the application to retain in your files or computer for future use. Attach all documentation shown on the next page to your application prior to mailing.

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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) and Wall Certificate with expiration date and number

_____ 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 logo from last 24 months (If Applicable)

_____ Mammo #s and MQSA (If Applicable)

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Please return all of the above requested documents in the enclosed envelope and mail to:

ATT:_____
Recruiter's Name

Locum Care LLC
760 Old Roswell Rd
Roswell, GA 30076
800.909.5675 toll free
888.220.5658 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

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Physician Initial Credentialing 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				Office Fax Number
	Citizenship	Birthplace	Date of Birth		Email address:
	Present Position		NPI #		Medicare #
	UPIN #		Fed Tax ID		Medicaid #
	Please provide the name and address of someone who will always know your forwarding address		Contact Name and Phone		Contact Address:
Education And Training	Medical School				Degree
	Dates (From mm/yy To mm/yy)		City		State
	PGY1 (Internship) Training -- Facility Name			City	State
	Dates (From mm/yy To mm/yy)		Category of Training		
	Residency Training -- Facility Name			City	State
	Dates (From mm/yy To mm/yy)		Specialty		
	Fellowship Training -- Facility Name			City	State
	Dates (From mm/yy To mm/yy)		Specialty		
	Additional Training -- Facility Name			City	State
	Dates (From mm/yy To mm/yy)		Category of Training		

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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?	
Licensing Exams Taken:	National Boards: Yes ☐ No ☐ Date Taken: _____	FLEX: Yes ☐ No ☐ Date Taken: _____	SPEX: Yes ☐ No ☐ Date Taken: _____	
	USMLE: Yes ☐ No ☐ Date Taken: _____	State Boards: Yes ☐ No ☐ Date Taken: _____ State: _____	LMCC: Yes ☐ No ☐ Date Taken: _____	

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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REFERENCES

Please list six ***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
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 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 Locumcare 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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CURRENT HOSPITAL AND OTHER FACILITY AFFILIATIONS

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 ☐

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

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DISCIPLINARY ACTIONS

If your answer to any of the following questions is "Yes", please provide a full explanation on the attached Credentialing Application Explanation Form 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	9. Participation in any private, federal, or state health insurance program (e.g. Medicare, Medicaid)? ☐ Yes ☐ No
5. Membership / Rights on any medical staff? ☐ 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 on the attached Professional Liability Claims Information Form..

	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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Current Continuing Medical Education

Please provide CME activity completed within the last 3 years. This summary form may be submitted in lieu of sending copies of your CME certificate(s) for internal credentialing; however, some facilities may require actual copies of your certificates for privileging. Please make as many copies of this page as needed.

Program Title	Date	Sponsoring Organization	# of CME's

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Professional Liability Claims Information Form

The following information is necessary to complete the credentialing verification process and will be kept confidential.
Please print or type answers to the following for any malpractice claims reported to your malpractice insurance carrier, opened, closed, dismissed, settled or paid. Please complete a separate form for each claim. One case per sheet only (please photocopy first if additional sheets are needed)

PROVIDER'S NAME (required):_____

1. Name of Patient Involved: _____ Age: _____
   Month and Year of Occurrence: ____/_____ Month and Year of Lawsuit: ____/_____
   Event Precipitating Claim:_____ Insurance Carrier at Time: _____

2. What is/was your status: ☐ Primary Defendant ☐ Co-defendant ☐ Other
   Please list other Defendants: _____

What was the patient's outcome? _____

How were you alleged to have caused harm or injury to this patient? _____

Please provide specifics in reference to the adverse event: _____

What is/was your role in this event? _____

Current Status***: (please check one)***

☐ Still pending: as of (date) ___/___/_____

Who is handling the defense of the case? _____

☐ Trial date set, awaiting trial? ☐ Yes ☐ No Trial Date: ____/___/_____

☐ Settled out of court? ☐ Yes ☐ No Date: ____/___/_____ Amount of Total Settlement: $ _____

Amount Paid on Your Behalf: $ _____

☐ Dismissed: Date: ___/___/_____

☐ Defense Verdict: Date: ___/___/_____

☐ Plaintiff Verdict: Date: ___/___/_____

☐ Judgment Amount: $ _____ Date: ___/___/_____ Amount of Total Judgment: $ _____

This professional Liability Claims Information Form is required on all claims/lawsuits. Clinical details are required for all suits, regardless of status or settlement amount.

I certify that the information contained in this form is correct and complete to the best of my knowledge.

Applicant's Signature: _____ **Date:** _____

Print Name: _____

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Credentialing Application Explanation Form

Please make as many copies of this page as needed to fully respond to each question for which you answered “yes”. Provide your name on each page if additional sheets are used.

Identify the Section of the application that you are providing an explanation for.

Provider Name: _____

SECTION/QUESTION#:	COMMENTS:

Applicant’s Signature: _____ **Date:** _____

Print Name: _____

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Authorization, Attestation and Release

(Credentialing/Licensing)

I acknowledge that LOCUMCARE has been engaged to provide 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") of a placement agency or other third party working for my benefit ("Agency"). I understand that LOCUMCARE must collect information from me and from third parties and share all or part of that information. Such information may include, for example, my current licensure, relevant education, training and experience, clinical competence, health status, character and ethics. I understand that with respect to the credentialing application process, the information will be evaluated along with such other criteria LOCUMCARE and the Client may consider for determining my initial and ongoing eligibility to provide healthcare services to or on behalf of the Client.

I further acknowledge and understand that my cooperation in providing and assisting LOCUMCARE in obtaining information and my consent to the release of information does not guarantee that a Client will grant me clinical privileges or contract with me as a provider of services. I understand that my credentialing application is not an application for employment and that acceptance of my application by LOCUMCARE or its Clients will not in itself result in my employment.

Agreement to Provide Information

I agree to provide on a timely basis as requested by LOCUMCARE sufficient and accurate information as deemed necessary or appropriate by LOCUMCARE for the completion, submittal and support of my credentialing applications.

Authorization of Investigation Concerning Application

I authorize LOCUMCARE and the Client, and their respective employees, affiliated entities and representatives and agents (together and individually the "Agents"), to collect, hold, and investigate information, which includes both oral and written statements, records, and documents, concerning or to be included in my credentialing applications. I agree to allow the Agents to inspect and copy all records and documents relating to my credentialing applications and to disclose any such information to the Client 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 to the Agents information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, 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 credentialing with LOCUMCARE 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 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 and 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 which is the subject of this Authorization, Attestation and Release. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for credentialing activities.

Licensing Application
If I have requested LOCUMCARE to assist me with 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"), then the foregoing agreements, authorizations and releases shall apply as well to the information gathering services and the uses of such information in furtherance of such License Applications. I acknowledge and understand the information will be shared with Boards and other third parties as may be necessary or appropriate for such License Applications process. I further acknowledge and understand that my cooperation in providing and assisting LOCUMCARE in obtaining information and my consent to the release of information does not guarantee that any state will grant me a license to practice medicine in that state.

Attestation
I certify that all information provided by me in connection with my credentialing application and, if applicable, my License 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 LOCUMCARE(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 in connection with my credentialing application (or License Applications) or authorized to be released to Agents in connection with the credentialing process (or License Applications).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand 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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Locum Tenens Practice Experience

List professional locum tenens experience in chronological order. Attach a separate sheet if necessary.

1. Facility	Phone	
Address	City, State, Zip	
Contact	Date from	To
2. Facility	Phone	
Address	City, State, Zip	
Contact	Date from	To
3. Facility	Phone	
Address	City, State, Zip	
Contact	Date from	To
4. Facility	Phone	
Address	City, State, Zip	
Contact	Date from	To
5. Facility	Phone	
Address	City, State, Zip	
Contact	Date from	To
6. Facility	Phone	
Address	City, State, Zip	
Contact	Date from	To
7. Facility	Phone	
Address	City, State, Zip	
Contact	Date from	To

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Authorization Agreement for Ach Credits (Direct Deposit)

_____ _____

Individual Name ID Number (Company Tax ID or SSN)

I (WE) hereby authorize Locumcare herein after called Individual, to initiate credit entries and/or correction entries to our ☐ *Checking* ☐ *Savings account (select one)* indicated below at the depository named below, herein called DEPOSITORY, to credit the same such account. I acknowledge that the origination of the ACH transactions to my account must comply with the provisions of the U.S. law.

_____ _____

DEPOSITORY NAME BRANCH

_____ _____

CITY STATE

_____ _____

BANK TRANSIT/ABA NUMBER (aka "routing number") ACCOUNT NUMBER

This authorization is to remain in full force until the Individual has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Individual and DEPOSITORY reasonable opportunity to act upon it.

_____ _____

NAME(S) TAX ID NUMBER (or SSN)

_____ _____

SIGNATURE DATE

_____ _____

SIGNATURE DATE

Please fax completed copy to 888-220-5658

After we receive your completed form, a prenote will be sent to your bank. Afterwards, we must wait six business days to allow time for your bank to validate your account information and get back to us if problems are encountered. Please keep this time frame in mind when anticipating your first direct deposit. If you have any questions concerning whether or not your check will be paper vs. electronic, please call us to verify.

Funds are deposited to your account the Friday following payroll. Payment information is sent to the bank, but the bank must have two business days for processing transactions.