Please complete the entire questionnaire. Print clearly and review any pre-filled information for accuracy. All areas must contain a response. Note "N/A" if not applicable. The questionnaire must be signed and dated by PROVIDER. Cirriculum Vitae's without completed questionnaire will not be considered. This questionnaire will be usd for professional screeninig and professional liability insurance underwriting purposes.

PRACTICE INTERESTS

☐ Emergency Medicine ☐ Family Practice ☐ Hospitalist ☐ Pediatrics

☐ Occupational Medicine ☐ Internal Medicine ☐ Urgent Care ☐ Other (Specify)_____

Geographic Preference(s): _____ Date Available: _____

PERSONAL

Last Name: _____ First Name: _____ Middle Initial: _____

Suffix: _____ Medical Degree: ☐ MD ☐ DO List any other name(s) under which you have been trained, licenses or certified: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Office Phone: _____ Home Fax: _____

Mobile Phone: _____ Pager:_____ Email: _____

Social Security Number: _____ UPIN: _____ NPI: _____

Are you legally authorized to work in the United States?	☐ Yes	☐ No
Are you currently in the military?	☐ Yes	☐ No
Are you currently an active reservist?	☐ Yes	☐ No
Will you now or in the future require sponsorship for employment visa status (e.g., H-1B visa status)?	☐ Yes	☐ No

This application will only be considered for the 120 calendar day period after dated above. Should you wish to be considered after this period, you must submit an updated attestation and authorization page(s).

ERgency and its related and affiliated entities are equal opportunity employers and comply with all laws prohibiting discrimination on the basis of such factors as race, color, age, sex, national origin, citizenship, and disability, as well as others protected by applicable law under the Michigan Persons with Disabilities Civil Rights Act and the federal Americas with Disabilities Act, the employer has legal obligations to accommodate a Michigan employee's or job applicant's disability unless the accommodation would impose an undue hardship on the employer. A disabled person may allege a violation against an employer regarding a failure to accommodate his or her disability under Michigan law only if the person notifies the employer in writing of the need for accommodation within 182 days after the date the disabled person knows or reasonably should have known that an accommodation was needed.

Applicant Name: _____

EDUCATION

Undergraduate Education			
College/University:		From: (MM/YY)	To: (MM/YY)
Address:	City, State, Zip:		
Degree:	Major:		
Graduate School/Additional Education			
College/University:		From: (MM/YY)	To: (MM/YY)
Address:	City, State, Zip:		
Degree:	Major:		
Medical Education			
College/University:		From: (MM/YY)	To: (MM/YY)
Address:	City, State, Zip:		
Degree:	Major:		
Undergraduate Education			
College/University:		From: (MM/YY)	To: (MM/YY)
Address:	City, State, Zip:		
Degree:	Major:		
ECFMG Certification (if applicable)			
Date of ECFMG Certification:	ECFMG number:		

POST GRADUATE TRAINING

If more than two internships, residencies or fellowships were started or completed, please supply the same information on a copy of this sheet and attach it this questionnaire.

Internship 1			
Type:	Hospital:	From: (MM/YY)	To: (MM/YY)
Address:	City, State, Zip:	Program Director:	
Phone:	Fax:	Email:	

Applicant Name: _____

Internship 2			
Type:	Hospital:	From: (MM/YY)	To: (MM/YY)
Address:	City, State, Zip:	Program Director:	
Phone:	Fax:	Email:	
Residency 1			
Type:	Hospital:	From: (MM/YY)	To: (MM/YY)
Address:	City, State, Zip:	Program Director:	
Phone:	Fax:	Email:	
Did you complete residency? ☐ Yes ☐ No If no, give details on a separate sheet			
Residency 2			
Type:	Hospital:	From: (MM/YY)	To: (MM/YY)
Address:	City, State, Zip:	Program Director:	
Phone:	Fax:	Email:	
Did you complete residency? ☐ Yes ☐ No If no, give details on a separate sheet			
Fellowship 1			
Type:	Hospital:	From: (MM/YY)	To: (MM/YY)
Address:	City, State, Zip:	Program Director:	
Phone:	Fax:	Email:	
Fellowship 2			
Type:	Hospital:	From: (MM/YY)	To: (MM/YY)
Address:	City, State, Zip:	Program Director:	
Phone:	Fax:	Email:	

Applicant Name: ____

PROFESSIONAL EXPERIENCE

Include all time periods since completion of medical school, including teaching appointments in chronoloical order from starting with most recent. (Exclude internships/fellowships/residencies listed on previous page). ***Please provide explanations for any time gaps.*** If additional space is needed, please list details on a separate paper.

Current Position			
Job Title:	Hospital:	From: (MM/YY)	To: (MM/YY)
Address:	City, State, Zip:	Supervisor/Medical Director:	
Phone:	Fax:	Email:	

Job Title:	Hospital:	From: (MM/YY)	To: (MM/YY)
Address:	City, State, Zip:	Supervisor/Medical Director:	
Phone:	Fax:	Email:	

Job Title:	Hospital:	From: (MM/YY)	To: (MM/YY)
Address:	City, State, Zip:	Supervisor/Medical Director:	
Phone:	Fax:	Email:	

Job Title:	Hospital:	From: (MM/YY)	To: (MM/YY)
Address:	City, State, Zip:	Supervisor/Medical Director:	
Phone:	Fax:	Email:	

Job Title:	Hospital:	From: (MM/YY)	To: (MM/YY)
Address:	City, State, Zip:	Supervisor/Medical Director:	
Phone:	Fax:	Email:	

Applicant Name: _____

Job Title:	Hospital:	From: (MM/YY)	To: (MM/YY)
Address:	City, State, Zip:	Supervisor/Medical Director:	
Phone:	Fax:	Email:	

EXAMINATIONS/CERTIFICATIONS/LICENSES

Board Name	Origianl Certification MM/DD/YY	Recertification Date MM/DD/YY	Expiration Date MM/YY	Prepared/Eligible MM/DD/YY	Scheduled For MM/YY
☐ ABEM					
☐ AOBEM					
☐ AAPS/BCEM					
☐ ABIM					
☐ AOBIM					
☐ ABFP					
☐ AOBFP					
☐ ABP					
☐ AOBP					
☐ Other					

NBME:	Date Passed (MM/YY)	FLEX:	Date Passed (MM/YY)
USMLE:	Date Passed (MM/YY)	Other:	Date Passed (MM/YY)

ACLS:	Date Passed (MM/YY)	Expiration Date (MM/YY)	BLS:	Date Passed (MM/YY)	Expiration Date (MM/YY)
ATLS:	Date Passed (MM/YY)	Expiration Date (MM/YY)	PALS/ APLS:	Date Passed (MM/YY)	Expiration Date (MM/YY)

If additional space is needed, please complete on a separate page and attach.

Medical License Number	State	Issue Date MM/DD/YY	Expiration Date MM/DD/YY	Status Active, Inactive, Temp or Pendng
1.				
2.				
3.				
4.				

Applicant Name: _____

DEA Registration Number	State	Issue Date MM/DD/YY	Expiration Date MM/DD/YY
State Controlled Substance Registration Number	**State**	**Issue Date MM/DD/YY**	**Expiration Date MM/DD/YY**

If additional space is needed, please complete on a separate page and attach.

Applicant Name: _____

PROFESSIONAL REFERENCES

Current Medical Director		
Name/Degree:	Facility:	Dates: (MM/YY – MM/YY)
Specialty:	Work Phone:	Home Phone:
Address:		Fax:
City, State Zip:	E-mail:	
Former Medical Director		
Name/Degree:	Facility:	Dates: (MM/YY – MM/YY)
Specialty:	Work Phone:	Home Phone:
Address:		Fax:
City, State Zip:	E-mail:	
Residency Program Director		
Name/Degree:	Facility:	Dates: (MM/YY – MM/YY)
Specialty:	Work Phone:	Home Phone:
Address:		Fax:
City, State Zip:	E-mail:	
Department Colleague		
Name/Degree:	Facility:	Dates: (MM/YY – MM/YY)
Specialty:	Work Phone:	Home Phone:
Address:		Fax:
City, State Zip:	E-mail:	
Former Medical Director		
Name/Degree:	Facility:	Dates: (MM/YY – MM/YY)
Specialty:	Work Phone:	Home Phone:
Address:		Fax:
City, State Zip:	E-mail:	

Applicant Name: _____

Other		
Name/Degree:	Facility:	Dates: (MM/YY – MM/YY)
Specialty:	Work Phone:	Home Phone:
Address:		Fax:
City, State Zip:	E-mail:	

Applicant Name: _____

CLINICIAN ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to any question is "yes," please provide a copy of the state and/or federal order, if your answer to questions B through N is "yes," please provide full details on a separate sheet.

A. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration, or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, investigated, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license/registration or accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending? **If Yes, provide a copy of the state or federal order.** **Yes** ☐ **No** ☐

B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending? **Yes** ☐ **No** ☐

C. Have your clinical privileges, membership, contractual participation or employment by any **medical organization** (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer, medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? **Yes** ☐ **No** ☐

D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any **medical organization** (see definition in "**C.**" above) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? **Yes** ☐ **No** ☐

E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? **Yes** ☐ **No** ☐

F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending? **Yes** ☐ **No** ☐

G. Have you been denied certification/recertification by a specialty board, or has your eligibility, certification, or recertification status changed (other than changing from "eligible" to "certified")? **Yes** ☐ **No** ☐

H. Have you ever been convicted of any crime (other than a minor traffic violation or expunged convictions)? **Yes*** ☐ **No** ☐

[*****A yes response does not automatically disqualify a job applicant from further consideration. Each situation is evaluated relative to the job being sought.]

I. Has an adverse action report or a medical malpractice payment report ever been submitted about you to the National Practioners Data Bank? **Yes*** ☐ **No** ☐

J. Have you ever been subject to criminal or civil sanctions and/or penalties by the Department of Health and Human Services, Office of Civil Rights, or by any state attorneys general for violations of the Health Insurance Portability and Accountability Act (HIPAA)? **Yes** ☐ **No** ☐

K. Are you excluded, disbarred, or otherwise ineligible to participate in the Federal Healthcare program or Federal procurement or non-procurement programs? **Yes** ☐ **No** ☐

L. Do you currently use drugs illegally? **Yes** ☐ **No** ☐

M. Have any judgments been entered against you, or settlements been agreed to by you, in professional liability cases, or are there any professional liability lawsuits/arbitrations pending against you? Have you ever received a notice of intent? **Yes** ☐ **No** ☐

Applicant Name: _____

N. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? **Yes** ☐ **No** ☐
O. Is there any reason you may not be able to perform all the essential functions of your job as an emergency department and urgent care physician with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients? **Yes** ☐ **No** ☐ (The need for an accommodation does not necessarily bar employment. A determination will be made as to the effectiveness with which the accommodation will allow you to perform the essential functions of the position(s) and the hardship it would impose on the employer.)

I hereby affirm that the information submitted in sections two through seventeen and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material, omissions or misrepresentations may result in denial of my application or termination of my privileges, employment, engagement, or physician participation agreement.

Applicant Signature: _____ Date _____

*(Stamped signature is **not** acceptable)*

Applicant Name: _____

DISCLOSURE QUESTION SUMMARY

If you answered "yes" to any question(s) in the previous CLINICIAN ATTESTATION SECTION of this application, please provide us with detailed information inclduing the outcome and other parties involved. Please attach any supporting documentation. Please photocopy for additional summaries.

Question #: _____ Date of Occurrence: _____ Location: _____

Description:

Question #: _____ Date of Occurrence: _____ Location: _____

Description:

Question #: _____ Date of Occurrence: _____ Location: _____

Description:

Applicant Name: _____

Question #: _____ Date of Occurrence: _____ Location: _____

Description:

Question #: _____ Date of Occurrence: _____ Location: _____

Description:

Applicant Signature: _____ Date: _____

*(Stamped signature is **not** acceptable)*

Applicant Name: _____

UNDERSTANDING AND AUTHORIZATION

I certify that the information given in this application and related documentation is true and complete without qualification. I understand that ERgency, on behalf of itself or any of its related or affiliate entities, as well as any of its related or affiliated entities (the "Companies" collectively, or "applicable Company" individually) may investigate my work and professional history and verify all data given on this application, or related papers, or in interviews, and I authorize the Companies to do the same. I consent to the conduct of this inquiry and to the consideration of any statements of references or former employers that are given in response to the inquiry. I authorize all individuals, schools, present and past malpractice carriers, hospitals at which I've worked, and employers named, to provide information requested about me. I understand and acknowledge that each of the Companies is entitled to rely on the representations made by me in the hiring process, and therefore I understand and acknowledge no matter when a misrepresentation or omission is discovered, that any misrepresentation or omission of fact by me can result in immediate discharge at the applicable Company's sole discretion.

I also understand and acknowledge that, to the extent I am employed by any of the companies in any position, my employment and compensation is the will of the applicable Company, and can be terminated, with or without cause, and with or without notice, at any time at the option of either the applicable Company or myself. I further understand and agree that no manager, representative, agent or employee of the applicable Company, other than its President, has now or has had in the past, any authority to enter into any agreement of employment for any specified period of time, or to make any agreement which is contrary to, or a modification of, the above described employment relationship, and that any such agreement or representation must be in writing and signed by both myself and the President of the Company, in order for it to be effective.

I further understand and acknowledge that, as part of the hiring process and throughout my employment, if hired, I may be required to submit to medical/physical examinations (which may include tests for drugs and/or alcohol) at the applicable Company's discretion and expense.

Applicant Signature: _____ Date: _____

*(Stamped signature is **not** acceptable)*

Applicant Name: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

For the purpose of this authorization, I understand that the term "information" shall include but is not limited to both oral and written information, and shall include all records and documents, including medical records and otherwise privileged or confidential information. The phrase "bearing on my professional competence and qualification" shall mean material which provides an evaluation of my clinical ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for associate health professional staff, medical staff, and clinical privileges. The term "third parties" shall include other hospitals, trustees, medical staffs and licensing associations, managed care plans, colleagues, and other organizations or persons concerned with provider and/or physician performance and the quality of care.

By applying for employment, affiliation, appointment, reappointment, or credentialing services with ERGENCY (Emergency Physicians Medical Group) or any of its related or affiliated entities, or any of their respective clients, I hereby:

1. Authorize ERgency to share with any and all of its related or affiliated entities information provided by me and acquired regarding to me during the application process and thereafter except to the extent I specifically restrict that sharing of information in a written notice by me to ERgency.
2. Authorize each hospital or client of ERgency and its related or affiliated entities, and their representatives, to consult with administrators and members of medical staffs of other hospitals, institutions and with others with whom I have been associated, including past and present malpractice carriers, who may have information bearing on my professional competence and qualifications.
3. Authorize ERgency and its related or affiliated entities or their respective clients and their respective representatives to receive and inspect all information bearing on any professional competence and qualifications in accordance with respective hospital medical staff bylaws, rules, and regulations.
4. Acknowledge that "credentialing information," includes but is not limited to, all information on applications, references, data and reports which reasonably relates to qualifications, competency, ability to practice, professional ethics and conduct of an applicant, medical staff member, and or participating physician. This information may be shared between ERgency, its related or affiliated entities, its contracted hospitals and its credentials verification clients.
5. Authorize ERgency, its related or affiliated entities, their respective clients, and their respective representatives to query and report to the National Practitioner Data Bank as mandated by Title IV of Public Law 99-660, Health Care Quality Improvement Act of 1986.
6. Release from any and all liability each hospital, ERgency and each of its related or affiliated entities, their respective clients, and their representatives for their acts performed in good faith and without malice in connection with their evaluation of my professional competence and qualifications.
7. Release from any and all liability all third parties, which in good faith and without malice, provide to each hospital, ERgency and each of its related or affiliated entities, their respective clients, and their representatives information bearing on my professional competence and qualifications. I consent to the release of such information to those parties and agree to execute general and specific releases upon request of each hospital in accordance with its bylaws.
8. Attest that all information I have provided in this application and its attached documentation is true and complete without qualification.

Applicant Signature: _____ Date: _____

*(Stamped signature is **not** acceptable)*

Applicant Name: _____

MALPRACTICE CLAIM/ACTION HISTORY

This information is required and will be used for the PLI underwriting.Please list all claims in chronological order with the oldest (regardless of age). Please include presentation/chief complaint, allegation(s), settlements, verdicts, and total defense costs. Please label attachments, medical records, or attorney summaries with appropriate claim number below. Pleae photocopy for additional claims.

Patient/Plantiff	Type of Incident	Date if Incident (MM/DD/YY)	Date Claim/Suit (MM/DD/YY)
	☐ Claim ☐ Suit ☐ Other		
Your Status ☐ Primary ☐ Co-defendant ☐ Other : _____	Location of Incident State: _____ ☐ Urban ☐ Rural ☐ Suburban	Department Volume: Provider's workloads (pts/hr):	Mid-level Providers involved? ☐ Yes ☐ No
Case handed off to another physician? ☐ Yes ☐ No If yes, whom?	Patient's disposition Discharged Admitted Transferred Death:		Status: ☐ Pending ☐ Dismissed ☐ Closed ☐ Settled/Paid ☐ Your Portion
Date Closed: (MM/DD/YY)	Insurance Carrier:	Attorney/Claims Rep:	Documentation Attached: ☐ Yes ☐ No
Nature of Claim (including reason for presentation/chief complaint)			

Patient/Plantiff	Type of Incident	Date if Incident (MM/DD/YY)	Date Claim/Suit (MM/DD/YY)
	☐ Claim ☐ Suit ☐ Other		
Your Status ☐ Primary ☐ Co-defendant ☐ Other : _____	Location of Incident State: _____ ☐ Urban ☐ Rural ☐ Suburban	Department Volume: Provider's workloads (pts/hr):	Mid-level Providers involved? ☐ Yes ☐ No
Case handed off to another physician? ☐ Yes ☐ No	Patient's disposition Discharged Admitted Transferred Death:		Status: ☐ Pending

Applicant Name: _____

If yes, whom?			☐ Dismissed ☐ Closed ☐ Settled/Paid ☐ Your Portion
Date Closed: (MM/DD/YY)	Insurance Carrier:	Attorney/Claims Rep:	Documentation Attached: ☐ Yes ☐ No
Nature of Claim (including reason for presentation/chief complaint)			

Patient/Plantiff	Type of Incident	Date if Incident (MM/DD/YY)	Date Claim/Suit (MM/DD/YY)
	☐ Claim ☐ Suit ☐ Other		
Your Status ☐ Primary ☐ Co-defendant ☐ Other : _____	Location of Incident State: _____ ☐ Urban ☐ Rural ☐ Suburban	Department Volume: Provider's workloads (pts/hr):	Mid-level Providers involved? ☐ Yes ☐ No
Case handed off to another physician? ☐ Yes ☐ No If yes, whom?	Patient's disposition Discharged Admitted Transferred Death:		Status: ☐ Pending ☐ Dismissed ☐ Closed ☐ Settled/Paid ☐ Your Portion
Date Closed: (MM/DD/YY)	Insurance Carrier:	Attorney/Claims Rep:	Documentation Attached: ☐ Yes ☐ No
Nature of Claim (including reason for presentation/chief complaint)			

Applicant Name: _____

Patient/Plantiff	Type of Incident	Date if Incident (MM/DD/YY)	Date Claim/Suit (MM/DD/YY)
	☐ Claim ☐ Suit ☐ Other		
Your Status ☐ Primary ☐ Co-defendant ☐ Other : _____	Location of Incident State: _____ ☐ Urban ☐ Rural ☐ Suburban	Department Volume: Provider's workloads (pts/hr):	Mid-level Providers involved? ☐ Yes ☐ No
Case handed off to another physician? ☐ Yes ☐ No If yes, whom?	Patient's disposition Discharged Admitted Transferred Death:		Status: ☐ Pending ☐ Dismissed ☐ Closed ☐ Settled/Paid ☐ Your Portion
Date Closed: (MM/DD/YY)	Insurance Carrier:	Attorney/Claims Rep:	Documentation Attached: ☐ Yes ☐ No
Nature of Claim (including reason for presentation/chief complaint)			

Patient/Plantiff	Type of Incident	Date if Incident (MM/DD/YY)	Date Claim/Suit (MM/DD/YY)
	☐ Claim ☐ Suit* ☐ Other		
Your Status ☐ Primary ☐ Co-defendant ☐ Other : _____	Location of Incident State: _____ ☐ Urban ☐ Rural ☐ Suburban	Department Volume: Provider's workloads (pts/hr):	Mid-level Providers involved? ☐ Yes ☐ No
Case handed off to another physician? ☐ Yes ☐ No If yes, whom?	Patient's disposition Discharged Admitted Transferred Death:		Status: ☐ Pending ☐ Dismissed ☐ Closed ☐ Settled/Paid ☐ Your Portion
Date Closed: (MM/DD/YY)	Insurance Carrier:	Attorney/Claims Rep:	Documentation Attached:

Print Form

Applicant Name: _____

			☐ Yes ☐ No
Nature of Claim (including reason for presentation/chief complaint)			

Applicant Signature: _____ Date:_____

*(Stamped signature is **not** acceptable)*