

National Locum Solutions, Inc.

Document Check List **For locum tenens**

Please include the following documents with your NLS Application:

- Completed Application
- One copy each of all current State Medical License Cards
- One copy of your Federal D.E.A Certificate
- Copy of your medical malpractice (if applicable)
- Copy of Drivers license

- Any “yes” answers must be accompanied by a back up statement of explanation. In cases of disciplinary actions both past and present please provide support documentation and legal documentation. If there was a settlement in your name, we will need the amount and insurance company and broker information.

- Copies of all current (within the past year) ACLS, BLS.

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www.nationallocumsolutions.com

Please complete the application in its entirety. If a question **does not apply** to you **write N/A**. If additional space is required in answering any section of the, attach all information on a separate sheet of paper.

Last Name _____		First Name _____		Middle Initial _____	
Birth Name _____					
Home address _____				Apt number _____	
City/state/zip code _____					
Telephone number _____			Email address _____		
Date of birth _____			Place of birth _____		
Social security number _____			Citizenship _____		
Office address _____			Office telephone number _____		
Ste # _____		Federal ID number _____			
Drivers License # _____					
City, State Zip code _____				Degree: MD DO Other	
Are you eligible to work in the United States? Yes ___ No ___					

EMERGENCY CONTACT INFORMATION

Name _____		Telephone number _____	
Address _____		Relationship _____	
City, State, Zip code _____			

MILITARY STATUS

Have you ever served in the United States Military? Yes ___ No ___	
If yes, which branch? _____	
Type of discharge? _____	
Are you a: Disabled veteran? _____	
Veteran of the Vietnam Era? _____	
Veteran (other)? _____ Please explain: _____	

Primary Practice Specialty: _____
 Sub Specialties: _____
 Other medical interests in practice (research, forensics, academics, etc.) _____

 When are you available to work? _____
 Are you interested in permanent opportunities? _____
 What type(s) of practice opportunities would you prefer?
 In-patient ___ Out-patient ___ Urgent Care ___ Hospital ___ Solo practice ___
 Multi-Specialty Group ___ Clinic ___ Government Facility ___ Other ___
 Do you have any geographic preferences? _____

 Would you be willing to license in States that you are not currently licensed, should an interesting opportunity arise? _____

EDUCATION

Pre-Medical: _____
 College/University _____
 Degree _____
 Honors _____
 Date of graduation _____
 Address _____

MEDICAL EDUCATION

Medical School _____ Degree _____
 Address _____
 Dates Attended (MM/DD/YY) _____ Date of graduation _____

INTERNSHIP

Hospital/ Institution _____
 Address _____
 Dates attended (MM/DD/YY) _____
 Program Chairperson _____
 Type of Internship _____

RESIDENCY

Hospital Institution _____
Address _____
Dates attended (MM/DD/YY) _____
Type of Residency _____
Program Chairperson _____

CONTINUED EDUCATION

Fellowship(s) _____
Institution _____
Address _____
Dates Attended (MM/DD/YY) _____
Program Chairperson _____
Type of fellowship _____
Board Certification(s) _____
Specialty/Board _____ Certification Date _____
Re-certification Date _____
Board Eligibility _____

PROFESSIONAL ASSOCIATIONS / MEMBERSHIPS

List all professional associates and / or memberships that you are currently a member of: _____

WORK HISTORY

List Employers in reverse chronological order, beginning with the most recent employer. All dates from medical school to present must be accounted for. Should you have any gaps in your work history, list all dates and reasons on a separate sheet of paper. Also, if additional space is necessary, please attach on a separate sheet of paper.

Name of Institution: _____
Address _____
Telephone number _____
Dates Employed (MM/DD/YY) _____ Position _____

Name of Institution: _____
Address _____
Telephone number _____
Dates Employed (MM/DD/YY) _____ Position _____

Name of Institution: _____
Address _____
Telephone number _____
Dates Employed (MM/DD/YY) _____ Position _____

Name of Institution: _____
Address _____
Telephone number _____
Date Employed (MM/DD/YY) _____ Position _____

Reason for leaving most recent employer?

HOSPITAL AFFILIATION

List all hospital affiliations, in reverse chronological order, beginning with the most recent. If additional space is required, include a separate sheet of paper.

Name of Hospital: _____
 Telephone Number: _____
 Address: _____
 Staff Category: _____ Dates (MM/DD/YY): _____

Name of Hospital: _____
 Telephone Number: _____
 Address: _____
 Staff Category: _____ Dates (MM/DD/YY): _____

Name of Hospital: _____
 Telephone Number: _____
 Address: _____
 Staff Category: _____ Dates (MM/DD/YY): _____

Name of Hospital: _____
 Telephone Number: _____
 Address: _____
 Staff Category: _____ Dates (MM/DD/YY): _____

Licenses

List all current and past medical licenses.

State:	License number:	Issue Date:	Expiration date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Attach copies of all licenses. Please list any additional licenses on a separate sheet of paper. If a substance control number is required for any of the states listed above, attach copies with the license.)

UPIN Number	ACLS	ATLS	BLS	PALS
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D.E.A Registration Number: _____ Issue date: _____
 Expiration date: _____

LICENSURE AND CLAIMS HISTORY

(** If you answer “Yes” to any question, please provide a detailed explanation on a separate sheet of paper.**)

1) Have you ever been the subject of disciplinary or investigative proceedings or reprimanded by a governmental, administrative agency, hospital or professional association? Yes or No

2) Have you ever had any State professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or voluntary surrender of same? Yes or No

3) Have your hospital privileges and / or professional services ever been denied, revoked, suspended, refused, limited, placed on probation, or placed under and disciplinary action? Yes or No

4) Have there been or are there any pending malpractice claims, judgments, suits, settlements, or notice of intent to commence action involving you and / or your medical practice? Yes or No

5) Have you ever been convicted of an act committed in violation of any law or ordinance other than a traffic violation? Yes or No

6) Do you have now or have you ever had any problems with or been treated for drug or alcohol dependency? Yes or No

7) Have you ever had any professional liability insurance company cancel, decline, refuse to renew, or accept only on special terms, their malpractice insurance? Yes or No

HEALTH STATUS

Have you ever had or do you now have any physical or mental condition that would compromise your ability to practice medicine or perform clinical assignments?
Yes or No

PROFESSIONAL REFERENCES

Provide at least (3) three references from physicians who have had clinical contact with, and are capable of assessing your professional skills within the past 18 (eighteen) months.

Reference: _____
Address: _____

Telephone: _____ E-mail: _____

Reference: _____
Address: _____

Telephone: _____ E-mail: _____

Reference: _____
Address: _____

Telephone: _____ E-mail: _____

Reference: _____
Address: _____

Telephone: _____ E-mail: _____

Reference: _____
Address: _____

Telephone: _____ E-mail: _____

ATTESTATION AND AUTHORIZATION

I **certify** that the information on the application is true and complete to the best of my knowledge. I **authorize National Locum Solutions, Inc.** to release information contained in this application to its **Risk Management Department, insurance companies, and medical facility clients.**

I hereby **authorize** the disclosure by **any institution (including but not limited to the Federation of State Medical Boards and State Licensing Boards)** information regarding me, including my **education, medical training and employment, skills, experience, fitness to practice medicine, character, work habits, job performance, certification, licensure, hospital staff or clinical privileges, DEA authorization and medical malpractice claims.** The undersigned releases the above from any claims resulting from the disclosure of such opinions to **National Locum Solutions, Inc..**

Signature

Date

Print Name

AUTHORIZATION AND WARRANTY

I **authorize** the release of all information from **Medical Schools, Colleges, Universities, Medical Institutions, Hospitals, Clinics, Physicians, State Medical Boards, Medical Malpractice Carriers, All Government Agencies, and any other source necessary** to assist with my credentialing process.

I understand that all information will be used to **evaluate my professional qualifications, assist with credentialing at Health Care Facilities, and for use when applying to State Medical Boards for licensing are necessary.**

Signature

Date

Print Name