



SPECTRUM HEALTH SERVICES, INCORPORATED

PROVIDER APPLICATION for EMPLOYMENT

After completing and signing the following application, please use the checklist below for inclusion of copies of the required items except where indicated as “Original.”:

- Completed & signed Application
- Three (3) Letters of References
- Curriculum Vitae (include documentation re: gaps in employment)
- Explanation of any Malpractice Suits
- Copy of Medical School Diploma & Original Transcript
- Copy of Current PALS (Pediatricians Only)
- Letter re: Attestation Statement of Mental/Physical Health
- Copy of Current BLS
- Copy of DEA Certification (Must have Phila., PA Address)
- Copy of Current Malpractice Face Sheet
- Copy of State Licenses
- Copies of Current CME Credits (150 CME Credits req.)*
- Board Certification
- Copy of Social Security Card (req. for PA MEDICAID App)
- Delineation of Privileges

***Note: CME credits apply to providers with practical experience in their specialty.**

I. General Information

Name: _____
(Last) (First) (M.I.)

Address: _____
Street City State Zip Code

Telephone #: (_____) _____ Cell Phone/Beeper _____

E-mail Address: _____

Social Security #: _____ - _____ - _____

MD DO Other _____
(Check One)

Driver's License Number: _____ State: _____

Position applied for _____ Date of Application: _____

Referral Source: Advertisement Employee Relative Government Employment Agency

Private Employment Agency Other _____

Name of source (if applicable) _____

• If necessary, best time to call you at home is a.m. _____: _____ p.m.

• May we contact you at work?..... Yes No

• If yes, work number and best time to call.....(_____) _____ a.m. _____: _____ p.m.

• Type of employment desired: Full-Time Part-Time Temporary

• Salary desired: _____

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III. Education & Training

Premedical: _____
(Institution/s:) (City, State, County)

(Dates) (Degree/Certificate)

(Institution/s:) (City, State, County)

(Dates) (Degree/Certificate)

Medical
Education: _____
(Institution/s:) (City, State, County)

(Dates) (Degree/Certificate)

(Institution/s:) (City, State, County)

(Dates) (Degree/Certificate)

Internship: _____
(Institution/s:) (City, State, County)

(Dates) (Degree/Certificate)

(Institution/s:) (City, State, County)

(Dates) (Degree/Certificate)

Residency: _____
(Institution/s:) (City, State, County)

(Dates) (Degree/Certificate)

(Institution/s:) (City, State, County)

(Dates) (Degree/Certificate)

IV. Confidential Information

	Yes	No
1. Has your license to practice medicine ever been revoked? _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been subject to professional disciplinary procedures? _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been censured by a local or state professional organization? _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Have any of the following ever been revoked, suspended, reduced or not renewed?		
- Privileges at hospital or other health care institution? _____	<input type="checkbox"/>	<input type="checkbox"/>
- Membership or fellowship in local, state, or national professional organization? _____	<input type="checkbox"/>	<input type="checkbox"/>

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IV. Confidential Information

- | | Yes | No |
|--|--------------------------|--------------------------|
| - Specialty Board Certification? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Licenses to practice in any profession in your jurisdiction? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Drug Enforcement Agency License _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Have you ever been refused or dropped as a provider by an HMO/PPO? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Have you ever been convicted of a crime? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Are you legally eligible for employment in this country (I-9)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Are you currently having any medical problems that would adversely affect your ability to practice medicine? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Has your malpractice coverage ever been denied, revoked, changed or suspended for cause? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Has any malpractice carrier ever made an out-of-court settlement or paid a judgement of professional liability claim on your behalf? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Are you or have you been involved in a malpractice suit? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

(If you have responded “yes” to any of the above questions, please provide a brief summary of the details including current status on a separate sheet.)

V. Teaching Appointments, Memberships in Civic and Professional Organizations

List past or present teaching appointments and memberships in civic and professional organizations:

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Applicant Statement:

I certify that all information I have provided in order to apply for and secure work with the employer is true, complete and correct.

I understand that any information provided by me that is found to be false, incomplete or misrepresented in any respect, will be sufficient cause to (1) cancel further consideration of this application, or (2) immediately discharge me from the employer's service, whenever it is discovered.

I expressly authorize, without reservation, the employer, its representatives, employees or agents to contact and obtain information from all references (personal and professional), employers, public agencies, licensing authorities and educational institutions and to otherwise verify the accuracy of all information provided by me in this application, resume or job interview. I hereby waive any and all rights and claims I may have regarding the employer, its agents, employees or representatives, for seeking, gathering and using such information in the employment process and all other persons, corporations or organizations for furnishing such information about me.

I understand that the employer does not unlawfully discriminate in employment and no question on the application is used for the purpose of limiting or excusing any applicant from consideration for employment on a basis prohibited by applicable local, state or federal law.

I understand that this application remains current for only 30 days. At the conclusion of that time, if I have not heard from the employer and still wish to be considered for employment, it will be necessary to reapply and fill out a new application.

If I am hired, I understand that I am free to resign any time, with or without cause, and the employer reserves the right to terminate my employment with or without cause except as may be required by law. This application does not constitute an agreement or contract for employment for any specified period or definite period or definite duration. I understand that no supervisor or representative of the employer is authorized to make assurances to the contrary and that no implied oral or written agreements contrary to the foregoing express language are valid unless they are in writing and signed by the employer's CEO.

I understand that if I am hired, I will be required to provide proof of identity and legal authority to work in the United States and that federal immigration laws require me to complete an I-9 Form in this regard.

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE APPLICANT STATEMENT.

I certify that I have read, fully understand and accept all terms of the foregoing Applicant Statement.

Signature of Applicant: _____

Date: ____/____/____