EMERGENCY PRACTICE ASSOCIATES

Application

This application must be completed in its entirety and it must be legible. If any items are not applicable, enter N/A. Do not use "see CV" as a response to any of the questions.

(Complete all seven pages.)

Personal Information *(Please Print)*

Last Name	First Name	Middle Name (Required)	MD/DO	Soc. Sec.#
Office Address	City	State	Zip Code	Area Code—Telephone
Home Address	City	State	Zip Code	Area Code—Telephone
Pager #	FAX #	E-Mail Address		
SSN	UPIN	If you require payment to a corporation, please list name and Federal ID#.		

(Birthplace/County/City/State/Country) Date of Birth Sex

Are you a US Citizen? ❐ Yes ❐ No If No; Visa Type:______________________________ Visa Number: ____

(Attach Notorized Copy)

Single ❐ Married ❐ Name of Spouse:____

Please provide the name and address of someone who will always know your forwarding address.

Last Name	First Name	Initial	Relationship	
Home Address	City	State	Zip Code	Area Code—Telephone

Licensure **List All Past and Current Licenses** *Use additional sheet if necessary*

Medical License

State	License #	Original Issue Date	Date Expires	Active/Inactive/Pending
State	License #	Original Issue Date	Date Expires	Active/Inactive/Pending
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State	License #	Original Issue Date	Date Expires	Active/Inactive/Pending
State	License #	Original Issue Date	Date Expires	Active/Inactive/Pending

Federal DEA

D.E.A. Registration #	Issued to what State?	Date Issued	Date Expires
D.E.A. Registration #	Issued to what State?	Date Issued	Date Expires

State Controlled Substance Registration

State	Registration #	Date Issued	Date Expires

Education

Premedical Education

College or University | Degree | Area of Study/Major

Street | City | State | Zip | Date of Graduation Mo/Yr.

Medical Education

Medical School | Degree

Street | City | State | Zip | Date of Graduation Mo/Yr.

ECFMG

Number | Date Issued

Internship

Facility (Full Name)

Street | City | State | Zip | From: Mo./Yr. To: Mo/Yr.

Type/Specialty | **Program Supervisor/Director Name**

Residencies, Fellowships

List in chronological order. If additional space is required, attach a separate sheet.

Facility (Full Name)

Street | City | State | Zip | From: Mo./Yr. To: Mo/Yr.

Type/Specialty | **Program Supervisor/Director Name**

Facility (Full Name)

Street | City | State | Zip | From: Mo./Yr. To: Mo/Yr.

Type/Specialty | **Program Supervisor/Director Name**

Facility (Full Name)

Street | City | State | Zip | From: Mo./Yr. To: Mo/Yr.

Type/Specialty | **Program Supervisor/Director Name**

Teaching Appointments

List in chronological order. If additional space is required, attach a separate sheet.

Facility (Full Name)

Street | City | State | Zip | From: Mo./Yr. To: Mo/Yr.

Type | **Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept., etc.)**

Board Certification

❒ **Not Applicable** **Explain:** ____________________

❒ **Eligible**

Name of Board ____________________ Admissibility Dates: From ______/_______/______ to ______/_______/______

Written Examination: Completed ______/_______/_______ Scheduled ______/_______/_______

Oral Examination: Completed ______/_______/_______ Scheduled ______/_______/_______

❒ **Certification**

Name of Board ____________________ Certificate Number: ____________________

Original Certification Date: ______/_______/_______ Re-Certification Date(s): ______/_______/_______ , ______/_______/_______

Expiration Date: ______/_______/_______

Name of Board ____________________ Certificate Number:____________________

Original Certification Date: ______/_______/_______ Re-Certification Date(s): ______/_______/_______ , ______/_______/_______

Expiration Date: ______/_______/_______

Hospital Affiliations

List in chronological order

Use additional sheets if necessary

Facility Name Location (City, State) ❐ Active ❐ Courtesy ❐ Pending ❐ Other

Dates (mo/yr to mo/yr) ______ Dept/Service ______

~~❐ Emergency Medicine experience was obtained at this facility~~

~~If so, number of hours __________ Volume __________~~

Facility Name Location (City, State) ❐ Active ❐ Courtesy ❐ Pending ❐ Other

Dates (mo/yr to mo/yr) ______ Dept/Service ______

~~❐ Emergency Medicine experience was obtained at this facility~~

~~If so, number of hours __________ Volume __________~~

Facility Name Location (City, State) ❐ Active ❐ Courtesy ❐ Pending ❐ Other

Dates (mo/yr to mo/yr) ______ Dept/Service ______

~~❐ Emergency Medicine experience was obtained at this facility~~

~~If so, number of hours __________ Volume __________~~

Facility Name Location (City, State) ❐ Active ❐ Courtesy ❐ Pending ❐ Other

Dates (mo/yr to mo/yr) ______ Dept/Service ______

~~❐ Emergency Medicine experience was obtained at this facility~~

~~If so, number of hours __________ Volume __________~~

Facility Name Location (City, State) ❐ Active ❐ Courtesy ❐ Pending ❐ Other

Dates (mo/yr to mo/yr) ______ Dept/Service ______

~~❐ Emergency Medicine experience was obtained at this facility~~

~~If so, number of hours __________ Volume __________~~

Professional Practice

Include Military Experience

List in chronological order

List all professional career experience and mark appropriate box (include additional sheet(s) if necessary). Any chronological gaps must be explained.

Type: ❐ Practice ❐ Academic ❐ Locum Tenens ❐ Military ❐ Public Health ❐ Other ______

Company Name: ______

Company Address: ______

______

City: ______ State: ______ Zip Code: ______

Phone Number: (_____)______ Fax Number: (_____)______

Position: ______

Beginning Date: _____/_____/______ Ending Date: _____/______/______

Type: ❐ Practice ❐ Academic ❐ Locum Tenens ❐ Military ❐ Public Health ❐ Other ______

Company Name: ______

Company Address: ______

______

City: ______ State: ______ Zip Code: ______

Phone Number- (_____)______ Fax Number- (_____)______

Position: ______

Beginning Date- _____/_____/______ Ending Date- _____/______/______

Explain any time gaps in professional history ______

______

______

______

______

Additional Training And Experience

~~I verify that I have obtained the additional training and experience listed below. (May include training and experience from residency rotations.)~~

~~**I have accumulated more than _________ hours of Emergency Medicine experience from M/Y _________ to M/Y __________.**~~

~~**I have participated in the delivery of _________ newborns and cared for more than __________ pediatric patients.**~~

I have received training in the following: (Check all that apply)

•	❐	BLS	Date of Training _______________	Recommended Renewal Date _______________
•	❐	ACLS	Date of Training _______________	Recommended Renewal Date _______________
➢	❐	ATLS	Date of Training _______________	Recommended Renewal Date _______________
➢	❐	PALS/APLS	Date of Training _______________	Recommended Renewal Date _______________
	❐	NRP/NALS	Date of Training _______________	Recommended Renewal Date _______________
	❐	ALSO	Date of Training _______________	Recommended Renewal Date _______________
	❐	OTHER:	Date of Training _______________	Recommended Renewal Date _______________

• Required
➢ May be required initially or within 6-12 months of application at specific hospitals

References *(Please Print)*

List the names and addresses of professional references from training programs and/or current associates. One should be a department director or a physician of comparable authoritative status. References should be directly familiar with your medical abilities. Two of these references should have worked with you in the last three years, preferably in your specialty or emergency medicine.

Name	MD/DO		Specialty		Date of observation: From/To
Address			Relationship		
City	State	Zip	Phone	Fax	
Email					

Name	MD/DO		Specialty		Date of observation: From/To
Address			Relationship		
City	State	Zip	Phone	Fax	
Email					

Name	MD/DO		Specialty		Date of observation: From/To
Address			Relationship		
City	State	Zip	Phone	Fax	
Email					

Name	MD/DO		Specialty		Date of observation: From/To
Address			Relationship		
City	State	Zip	Phone	Fax	
Email					

Quality Focused Questions *If any of the following is answered in the affirmative, provide full explanation on a separate sheet.*

1. Have there ever been or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice? (If yes, explain on Claims Information Sheet.) ☐ Yes ☐ No
2. Have you ever been denied Professional Liability Insurance? ☐ Yes ☐ No
3. Have you ever had your professional liability insurance limited, cancelled, non-renewed or provided at higher than the standard premium for any reason? ☐ Yes ☐ No
4. Has your license to practice medicine in any jurisdiction ever been limited, suspended, or revoked, or have you ever voluntarily surrendered your license? ☐ Yes ☐ No
5. Has your DEA registration ever been suspended, revoked, limited, made probationary, not renewed, or voluntarily suspended? ☐ Yes ☐ No
6. Have your privileges at any hospital ever been denied, revoked, suspended, limited or involuntarily non-renewed? ☐ Yes ☐ No
7. Have you ever voluntarily withdrawn or resigned from any hospital privileges or staff membership? ☐ Yes ☐ No
8. Is there currently any action, proceeding or investigation being undertaken concerning your license(s) to practice medicine, your DEA registration or any hospital privilege? ☐ Yes ☐ No
9. Have you ever been convicted of a felony? ☐ Yes ☐ No
10. Have you ever been denied membership, renewal or been subject to disciplinary action by any medical society, board, or organization? ☐ Yes ☐ No
11. Have you ever been under punitive or disciplinary observation/preceptorship at any hospital? ☐ Yes ☐ No
12. Regarding Medicare, Medicaid, or any other governmental health-related programs; have you ever been convicted of a crime or been subject to civil penalties, disciplinary proceedings, investigations, denial of or suspension from participation, or had any type of sanction? ☐ Yes ☐ No
13. Have you ever had, do you now have or have you ever been under treatment for a substance abuse or mental illness? If "yes" please provide details of rehabilitation program, including dates of treatment. ☐ Yes ☐ No
14. Do you presently have a physical, mental, or emotional condition (including alcohol or drug dependence) that affects or is reasonably likely to affect your ability to perform your professional duties appropriately or which could adversely affect the quality of care rendered by you to patients or jeopardize the safety of patients? ☐ Yes ☐ No

Immune Status Information

Please provide immunity status history by checking the appropriate boxes below. Some facilities require evidence of immunity before granting membership/participation.

1. MEASLES (RUBEOLA) IMMUNITY: Documentation of immunity to measles (rubeola) defined as one of the following:
☐ Two doses of measles (M), measles/rubella (MR), or measles, mumps, rubella (MMR) vaccine since 12 months of age received after 1967:
DATES: ________________ _________________
☐ One dose of measles (M), measles/rubella (MR), or measles, mumps, rubella (MMR) vaccine within the last year: DATE:___________________
☐ Positive serology indicating immunity (antibody test) - ENCLOSE DOCUMENTATION

2. RUBELLA IMMUNITY: Documentation of immunity to rubella defined as one of the following:
☐ At least one dose of measles/rubella (MR), or measles, mumps, rubella (MMR) vaccine: DATE: ______________________________________
☐ Positive serology indicating immunity to rubella - ENCLOSE DOCUMENTATION

3. MUMPS IMMUNITY: Documentation of immunity to mumps defined as one of the following:
☐ Date of birth before 1/1/57
☐ At least one dose of measles, mumps, rubella (MMR) or mumps vaccine: DATE: ____
☐ Positive serology indicating immunity to mumps- ENCLOSE DOCUMENTATION

4. HEPATITIS B IMMUNITY: Documentation of immunity to Hepatitis B as defined as one of the following:
☐ Completion of Hepatitis B vaccine series; YEAR OF SERIES:____
☐ Positive serology for Hepatitis B surface antibody indicating immunity to Hepatitis B- ENCLOSE DOCUMENTATION

5. TUBERCULOSIS STATUS:
☐ Have a positive TB skin test; Date of last chest x-ray:________________ Results:________________ if positive; treatment_________________
☐ Have had the disease; DATE:____________ treatment/follow/up:____________________________________ last chest x-ray:______________

☐ **DATE OF LAST PPD/MANTOUX:**_________________________ **Results:**____
(PPD within 12 months of seeking appointment; repeated annually)

____ ____ ____________
Name (Please type or print) Signature Date

Consent for release of information

I hereby authorize and consent to the release of information to Emergency Practice Associates and its subsidiaries. By applying for a position with Emergency Practice Associates and its subsidiaries, I hereby signify my willingness to appear for interviews if necessary, authorize subsidiary Hospitals of Emergency Practice Associates and their Medical Staffs and their representatives to consult with Administrators and members of Medical Staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications.

I hereby release from liability all representatives of Emergency Practice Associates for their acts performed in good faith and without malice in connection with the evaluation of my qualifications and my credentials, and I hereby release from any liability any and all individuals and organizations who provide information in good faith and without malice concerning my professional competence, ethics, character and other qualifications for appointment and privileges.

I understand and agree that I have the burden of producing adequate information of proper evaluation for my professional competence, character, ethics and other qualifications for resolving any doubts about such qualifications. I also understand this authorization will continue in force for the duration of my relationship with Emergency Practice Associates.

______________________________	______________________________	__________
Name (Please type or print)	Signature	Date

Acknowledgement and Signature

- **I understand and acknowledge the following relating to the Health Insurance Portability and Accountability Act ("HIPAA"):**

  1. HIPAA requires health care providers to protect the privacy of all patient health information.
  2. Bona fide Business Associates may have access to individually protected health information.
  3. As a Business Associate of Emergency Practice Associates, I may use and disclose individually protected health information to perform functions, activities or services for Emergency Practice Associates and its subsidiaries as required by law.
  4. Any other disclosure of a patient's protected health information is not permissible and would violate the Privacy Rules established by HIPAA. Such a violation would be considered a breach of this relationship resulting in immediate termination from further responsibilities and possible legal action by the Protected Entity.

- **I understand and acknowledge that Emergency Practice Associates will pursue Medical Staff privileges at affiliated hospitals on my behalf and with my consent. In the event the Emergency Practice Associates-hospital relationship is terminated, I further understand these privileges will be voluntarily withdrawn.**

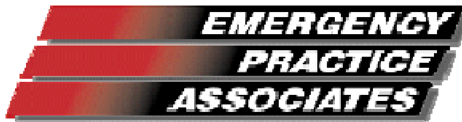
- **All information submitted by me in this application is true to my best knowledge and belief.**

______________________________	______________________________	__________
Name (Please type or print)	Signature	Date

Be Sure To Complete All Seven Pages

P.O. Box 1260 • Waterloo, Iowa 50704
Ph. (319) 236-3858 • (800) 458-5003
Fax (319) 236-3644
www.epamidwest.com

Please attach photo here (Required)



Hospitalist Core Competencies

Core competencies include admission, work-up, diagnosis, and provision of non-surgical treatment including consultation for adults. Non-surgical treatment includes consultation for patients admitted or in need of care to treat general medical problems. Consideration should be given to seeking consultation when a diagnosis is obscure, treatment response seems delayed, when treatment or procedures place the patient at high risk, when the patient develops unexpected complications or when consultation is requested by the patient or family.

- Arterial line placement
- Arterial puncture
- Cardiac pacing - temporary
- Cardiopulmonary resuscitation
- Central Venous Catheterization
- EKG interpretation
- Endotracheal Tube Intubation
- Gender-specific diseases – counseling, detection, prevention, diagnosis and treatment of
- Lumbar puncture
- Nasogastric intubation and placement of small bowel feeding and decompression tubes
- Paracentesis – diagnostic or therapeutic
- Swan Ganz catheter placement
- Thoracentesis – diagnostic or therapeutic
- Thrombolytic therapy
- Venipuncture
- Ventilator management

I certify that I am fully trained, competent and physically capable of performing the Core Competencies listed above. I understand I can also perform other procedures that are necessary to save the life and/or limb of patients under my care.

Signature:____ Date:_________________________

Physician Name:____
(Print)

APPLICATION CHECKLIST

If you have questions when completing the applications, please contact EPA at 800-458-5003.

HOSPITALISTS

REQUIRED APPLICATIONS

- ❑ **EPA Independent Contractor Application**
- ❑ **Hospitalist Core Competencies Form**
- ❑ **Physician and Surgeons Professional Liability Application (MMIC) – if applicable**

REQUIRED ITEMS

Please forward copies of the following items. **If initially you do not have all of the necessary documents, you may start the process by sending the completed application.**

- ❑ **Curriculum Vitae** – Should include activities through the current year.
- ❑ **Green Card/VISA/Certificate of Naturalization**– if applicable
- ❑ **Copy of your DD-214** (Prior Military Only)
- ❑ **Photo-**any size will suffice. The photo will be scanned and resized as needed. Please mail or email this item.
- ❑ **Government Issued ID** (i.e. driver's license, passport) required in addition to the photo–Please mail or email this item.
- ❑ **Medical License(s)**–Include copies of all Active and Inactive licenses including the initial licensure certificate if available.
- ❑ **State Controlled Substance Registration Certificate(s)** – n/a for MN
- ❑ **Federal DEA**
- ❑ **ECFMG**– Applicable to graduates of international medical schools only
- ❑ **Medical School Diploma**
- ❑ **Residency Certificate –** n/a for current residents
- ❑ **Fellowship Certificate –** n/a for current fellows
- ❑ **Board Certificate**– if applicable
- ❑ **List of CMEs obtained within the past 24 months** – n/a for residents/fellows.
  Include course title, date, and number of hours obtained or copies of the certificates
- ❑ **ACLS** – required at ALL facilities
- ❑ **Documentation of PPD/Mantoux test placed/read within the past 12 months**–
  If past positive, please provide a copy of your last chest x-ray.
- ❑ **Documentation of Rubella Immunization or Titer**

Created 04/07/06 - Revised 06/16/06, 09/11/07, 02/15/08, 02/01/12
S:\WORD\DOC\Forms-Originals\Credentialing forms\Checklist to add to EPA packet-IM ONLY.doc