

# 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If No; Visa Type: _____ Visa Number: _____				
Single <input type="checkbox"/> Married <input type="checkbox"/>		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
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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
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## 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

<hr/> <b>Facility Name</b> <hr/>	<hr/> <b>Location (City, State)</b> <hr/>	<input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Other
<hr/> Dates (mo/yr to mo/yr) <hr/>	<hr/> Dept/Service <hr/>	<input type="checkbox"/> Emergency Medicine experience was obtained at this facility If so, number of hours _____ Volume _____
<hr/> <b>Facility Name</b> <hr/>	<hr/> <b>Location (City, State)</b> <hr/>	<input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Other
<hr/> Dates (mo/yr to mo/yr) <hr/>	<hr/> Dept/Service <hr/>	<input type="checkbox"/> Emergency Medicine experience was obtained at this facility If so, number of hours _____ Volume _____
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<hr/> Dates (mo/yr to mo/yr) <hr/>	<hr/> Dept/Service <hr/>	<input type="checkbox"/> Emergency Medicine experience was obtained at this facility If so, number of hours _____ Volume _____
<hr/> <b>Facility Name</b> <hr/>	<hr/> <b>Location (City, State)</b> <hr/>	<input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Other
<hr/> Dates (mo/yr to mo/yr) <hr/>	<hr/> Dept/Service <hr/>	<input type="checkbox"/> 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)**



## Emergency Medicine Core Competencies

Core competencies include being able to assess, work up and provide initial treatment to **all** (adult & pediatric) patients who present to the ED with any illness, injury or symptom. An emergency physician is expected to provide stabilizing treatment to patients presenting with major illnesses or injuries and to assess **all** patients in order to determine if more definitive services are necessary.

- Acute airway management including intubation techniques and Cricothyrotomy.
- Cardiopulmonary Resuscitation
- Cardiac Pacing, External
- Cardioversion/Defibrillation
- EKG Interpretation – preliminary
- Radiologic Interpretation – preliminary
- Chest Tube Insertion
- Peripheral and Central Venous Access
- Lumbar Puncture
- Local Anesthesia
- Digital Nerve Block
- Wound Management and Repair
- Incision and Drainage of Abscess
- Fracture/Dislocation Immobilization
- Cervical Spine Immobilization
- Foreign Body Removal – Eye uncomplicated
- Corneal Abrasion - simple
- Foreign Body Removal – ENT – uncomplicated
- Epistaxis Control
- Delivery of Newborn – emergency only
- Sexual Assault Exam
- Initial ordering of diagnostic studies and evaluation of results.

### Initial Treatment and Management of:

- Acute Surgical Emergency
- Acute Medical Emergency
- Pediatric Emergency
- OB/GYN Emergency
- Cardiac Emergency
- Respiratory/Pulmonary Emergency
- Orthopedic Emergency
- Endocrine Emergency
- Psychiatric Emergency

***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.*

## REQUIRED APPLICATIONS

- EPA Independent Contractor Application**
  - Photo required by hospitals. Must be recognizable.
- Emergency Medicine Core Competencies Form**
- Medical Professional Liability Application (ProAssurance Wisconsin Company)**
  - \* EPA's liability insurance carrier.
  - \* All practitioners who intend to work on behalf of EPA must get approval from ProAssurance Wisconsin Company before they will be able to provide services.

## DOCUMENTS (copies) AND INFORMATION REQUIRED IN ADDITION TO THE APPLICATIONS

(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** – if applicable
- Copy of your DD-214 (Prior Military Only)**
- Photo** - any size will suffice. EPA will scan and adjust as needed.
- Government Issued ID** – (i.e. drivers license, passport) - New requirement of Joint Commission, which includes many of our client facilities
- Medical License(s)** – Both original and renewal when available. Include all active state licensures
- Controlled Substance Certificate(s)** – Required in IA, SD, & MO
- Federal DEA**
- ECFMG**– Applicable to graduates of international medical schools only
- Medical School Diploma**
- Residency Certificate** – n/a for current residents
- Board Certificate**– if applicable
- List of CMEs obtained within the past 24 months** – n/a for residents/fellows
- ACLS** – required at ALL facilities
- ATLS** – required for **IA**: ALL facilities; and **MN**: Hibbing, Little Falls, Paynesville
- PALS** – required for **IA**: Boone, Cedar Falls, Manchester, Mt. Pleasant, Newton, Red Oak; and **MN**: Hibbing
- Evidence of Completion of Mandatory Reporter Training** – required for Cedar Falls only
- Documentation of PPD/Mantoux test placed within the past 12 months**– if past positive, please provide a copy of your last chest x-ray.
- Loss History Report(s)**– EPA's malpractice carrier requires this for ALL applicants for the past 10 years. The loss history report can be obtained from your malpractice carrier. Please contact your carrier directly and ask them to send you a "loss history" report. This report verifies for ProAssurance Wisconsin Company the amounts paid out, if any, on your behalf.

The certifications listed below are not required, however, if you have completed any of the following, please send a copy of your certification card.

- NRP/NALS
- BLS
- ABLIS
- ALSO