



Address: 800 W. Frontier Lane Olathe, KS, 66061 Office: (913) 397-7800 Fax: (913) 397-7801

Email: staff@docswhocare.com Website: www.docswhocare.com

PHYSICIAN APPLICATION

Complete application fully and return with a copy of your Curriculum Vitae or Resume. (Please use print)

Name, Home Address, City/State/Zip, Place of Birth, Are you a U.S. citizen, Other names, If not a U.S. citizen, SSN, Have you served in the U.S Military, Emergency Point of Contact, Prof Designation, Home, Work, Mobile, May we contact you via text?, Fax, E-Mail, Date of Birth

PROFESSIONAL EDUCATION

List all medical schools/institutions attended (Include Month/Year). Please explain any gap greater than 30 days in your education or training. (Attach additional sheets if necessary)

Medical Education

School Name, City/State, Degree, Dates attended from, to

Post Graduate Education/ Internship/ Residency

1. Hospital/Program, Address, Phone, Fax, City/State/Zip, Dates attended from, to, Specialty, Program Director, Email; 2. Hospital/Program, Address, Phone, Fax, City/State/Zip, Dates attended from, to, Specialty, Program Director, Email

Fellowships

Hospital/Program, Address, Phone, Fax, City/State/Zip, Dates attended from, to, Specialty, Program Director, Email

SPECIALTY CERTIFICATION

Attach copy of certificate(s). If not applicable to your profession/specialty, complete with n/a.

Board Certification Name, Certification Number, Initial Date of Certification, Expiration Date of Current Certification, List all Recertification Dates, If not certified, indicate current status and/or date intending to sit for boards

PROFESSIONAL LICENSE / CERTIFICATION / REGISTRATION NUMBERS

List all states in which you have held, or currently hold, a license to practice your profession. Please attach copies.

State _____ Number _____ Issue Date _____ Expiration Date _____ Status _____

State _____ Number _____ Issue Date _____ Expiration Date _____ Status _____

State _____ Number _____ Issue Date _____ Expiration Date _____ Status _____

Federal Drug Enforcement Agency (DEA) # _____ Expiration Date _____

State Controlled Substance license(s) _____ State _____ Expiration Date _____

Medicare # _____ Medicaid # _____ Licensing States(s) _____

CAQH Provider # _____ National Provider Identifier (NPI) _____

If you are a graduate of a foreign medical school, are you certified by the Education Council for Foreign Medical Graduates (ECFMG)? **Yes No** (If yes, enclose a copy of your certificate with this application.) ECFMG Number _____

CERTIFICATIONS

Attach a copy of your current certificate(s).

ATLS Yes _____ No _____ Expiration _____ **PALS** Yes _____ No _____ Expiration _____

ACLS Yes _____ No _____ Expiration _____ **BLS** Yes _____ No _____ Expiration _____

EMPLOYMENT HISTORY

List current employer and last two employers (include Month/Year). Attach additional sheets if necessary.

1. **Current** Employer _____ Dates from _____ to _____
(mm/yyyy) (mm/yyyy)

Address _____ City/State/Zip _____

Phone _____ Fax _____ Contact Person _____ Email _____

2. **Previous** Employer _____ Dates from _____ to _____
(mm/yyyy) (mm/yyyy)

Address _____ City/State/Zip _____

Phone _____ Fax _____ Contact Person _____ Email _____

3. **Previous** Employer _____ Dates from _____ to _____
(mm/yyyy) (mm/yyyy)

Address _____ City/State/Zip _____

Phone _____ Fax _____ Contact Person _____ Email _____

HOSPITAL AFFILIATIONS

List all hospitals at which you hold or have held privileges (include Month/Year). Attach additional sheets if necessary.

Key: 1 Active 2 Temporary 3 Courtesy 4 Provisional 5 Other _____

1. **Primary** Hospital _____ Phone _____ Fax _____

Address _____ City/State/Zip _____

Status of Privileges (see key) _____ Dates from _____ to _____
(mm/yyyy) (mm/yyyy)

2. **Other** Hospital _____ Phone _____ Fax _____

Address _____ City/State/Zip _____

Status of Privileges (see key) _____ Dates from _____ to _____
(mm/yyyy) (mm/yyyy)

3. **Other** Hospital _____ Phone _____ Fax _____

Address _____ City/State/Zip _____

Status of Privileges (see key) _____ Dates from _____ to _____
(mm/yyyy) (mm/yyyy)

PROFESSIONAL LIABILITY INSURANCE

Attach a copy of your current certificate(s) or declarations(s) of insurance.

Carrier Name _____ Policy Number _____

Dates of Coverage from _____ to _____

Policy Limits: Per Occurrence \$ _____ Aggregate \$ _____

If you do not have Professional Liability insurance to cover your work with Docs Who Care, do you wish to apply for Professional Liability insurance through DWC? _____ Yes _____ No

Note: Coverage is available for all states with the exception of Kansas. Applications must be approved and coverage is not guaranteed.

REFERENCES

List the names and addresses of professional references from training programs and/or current associates. References must be physicians in your same professional discipline and should not include Program Directors, as they will complete a Verification of Residency form. You must have worked with your references within the past 24 months, and they should be directly familiar with your medical abilities during that time.

1. Name/Title _____ Specialty/Relationship _____

Hospital/Organization Address _____

City/State/Zip _____ Known from _____ to _____

(mm/yyyy)

(mm/yyyy)

Phone _____ Fax _____ Email _____

2. Name/Title _____ Specialty/Relationship _____

Hospital/Organization Address _____

City/State/Zip _____ Known from _____ to _____

(mm/yyyy)

(mm/yyyy)

Phone _____ Fax _____ Email _____

3. Name/Title _____ Specialty/Relationship _____

Hospital/Organization Address _____

City/State/Zip _____ Known from _____ to _____

(mm/yyyy)

(mm/yyyy)

Phone _____ Fax _____ Email _____

4. Name/Title _____ Specialty/Relationship _____

Hospital/Organization Address _____

City/State/Zip _____ Known from _____ to _____

(mm/yyyy)

(mm/yyyy)

Phone _____ Fax _____ Email _____

PERSONAL HISTORY

Include a brief summary of your personal history. This may include special interests, volunteer participation, personal goals, etc.

POSITION DESIRED

Indicate the desired type of position and approximate start date. Preferred Start Date: _____

_____ PRN

_____ One-Year Commitment or Longer

_____ Less than One-Year Commitment

_____ Other _____

HOW DID YOU HEAR ABOUT DWC

Check the appropriate box and provide additional information, if applicable.

Mailing _____ Website _____ DWC Provider: _____ Other _____

ADDITIONAL INFORMATION

If the answer to any of the following is "yes," please give details on a separate sheet.

- | | |
|--|--------------------|
| 1. Has your authority to practice in any state been suspended, revoked, voluntarily or involuntarily surrendered, been subject to a consent or stipulation order, not renewed, denied renewal, or has probation ever been invoked? | Yes _____ No _____ |
| 2. Have you ever been refused membership on a hospital medical staff? | Yes _____ No _____ |
| 3. Have any of your board certifications ever been suspended, revoked, not renewed, denied renewal, or voluntarily or involuntarily surrendered? | Yes _____ No _____ |
| 4. Has your request for any specific clinical privilege ever been denied or granted with state limitations? | Yes _____ No _____ |
| 5. Have your privileges at any hospital ever been suspended, diminished, or revoked? | Yes _____ No _____ |
| 6. Have you ever been named as a defendant in any criminal case? | Yes _____ No _____ |
| 7. Has your federal or state controlled substance license ever been suspended, revoked voluntarily, or involuntarily surrendered, restricted, not renewed, denied renewal, or has probation ever been invoked? | Yes _____ No _____ |
| 8. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization? | Yes _____ No _____ |
| 9. Have you ever been subject to a Professional Liability Claim? | Yes _____ No _____ |
| 10. Have you ever received treatment for alcoholism, drug abuse, or psychiatric disorders. | Yes _____ No _____ |
| 11. Have you ever been convicted, pled guilty, or pled nolo contendere to any felony, any offence reasonably related to your qualifications, functions, or duties as a medical professional, or any offense an essential element of which is fraud, dishonesty, or an act of violence? | Yes _____ No _____ |
| 12. Have you ever been denied a medical license? | Yes _____ No _____ |
| 13. Has your Medicare or Medicaid participation ever been suspended or revoked? | Yes _____ No _____ |
| 14. Have you ever voluntarily surrendered, limited, or suspended your license to practice medicine in any jurisdiction, under threat of investigation, order of consent invoked by any jurisdiction, or as a settlement to an investigation by a jurisdiction in lieu of threatened mandated revocation or suspension? | Yes _____ No _____ |
| 15. Have you ever voluntarily surrendered, limited or suspended your privileges at any hospital under threat of investigation, order of consent invoked by any hospital or as a settlement to an investigation by a hospital in lieu of threatened mandated revocation or suspension? | Yes _____ No _____ |
| 16. Have you ever voluntarily surrendered, limited or suspended your state or federal narcotics registration under threat of investigation, order of consent invoked by any state or the federal government or as a settlement to an investigation by a state or the federal government in lieu of threatened mandated revocation or suspension? | Yes _____ No _____ |
| 17. Have you ever been denied, revoked, or had canceled your Professional Liability Insurance? | Yes _____ No _____ |
| 18. Have you discontinued practice for any reason (other than routine vacation) for one month (30 days) or more? | Yes _____ No _____ |
| 19. Within the last five years, have you ever been reprimanded or disciplined in any manner by any state licensing authority or other professional board or peer review committee for conduct related to the use of alcohol or the use of any drug? | Yes _____ No _____ |
| 20. Has any information on you ever been reported to the National Practitioner Data Bank? | Yes _____ No _____ |

**** If the answer to any of the above is "yes," please give details on a separate sheet. ****

Applicant agrees 1) that the information contained herein and the references obtained and verification received in connection with processing this application may be disclosed to any professional insurance company, hospital or healthcare facility, 2) that all of the information contained herein is true and correct and that if anything contained herein is false, Docs Who Care may immediately terminate any contract entered into with applicant, and 3) that applicant shall notify Docs Who Care if any of the answers or information contained herein becomes incorrect or incomplete. This release is valid for a period of one year from date below:

Signature _____ Date _____

Name (Please Print) _____



Address: 800 W. Frontier Lane Olathe, KS, 66061 **Office:** (913) 397-7800 **Fax:** (913) 397-7801

Email: staff@docswhocare.com **Website:** www.docswhocare.com

PROVIDER RELEASE OF INFORMATION

In applying for assignment with **Docs Who Care**, I hereby signify my willingness to appear for interviews and consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications, including photographs of me, between **Docs Who Care** and other health care institutions (e.g.) hospitals, medical staffs, medical groups, independent practice associations, health plans, health maintenance organizations, managed care entities, other health delivery systems or entities, medical societies, professional societies, medical school faculty training programs, professional liability insurance companies, licensing authorities and business and individuals acting as their agents – collectively “Institutions”, for the purpose of evaluating my application and any recertification regarding my professional training, experience, character, conduct, judgment, ethics and ability to work with others. In this regard the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect peer review records from being further disclosed.

I understand that proprietary information related to locations, compensation, and hospital specific details will be shared, and agree not to use this information to seek opportunities directly with any medical care facilities under agreement, or in process of agreement, with **Docs Who Care**.

I release **Docs Who Care** and other institutions and their respective directors, officers, medical staffs, employees and agents or other independent contractors from any liability that **Docs Who Care** or other institutions may incur as a result of disclosing such information in accordance with the foregoing to the fullest extent provided under state or federal laws.

I further authorize and consent to the release of information by **Docs Who Care** to other hospitals and their medical staffs, medical associations or health care organizations on request regarding information that **Docs Who Care** may have concerning me as long as such release is done in good faith and without malice and I also release from liability **Docs Who Care** for so doing.

Signature _____ Date _____

Name (Please Print) _____

A photocopy or facsimile of this document shall be as effective as the original.

DOCUMENT CHECKLIST

The following is a list of required documents necessary to complete your application:

- _____ Copy of Curriculum Vitae or Resume
- _____ Copy of Medical School Diploma (as well as ECFMG Certificate, if applicable)
- _____ Copy of Internship, Residency, and Fellowship Certificates
- _____ Copy of Board Certification (if applicable)
- _____ Copy of Other Certifications (ATLS, ACLS, PALS, etc)
- _____ Copy of Current State Medical License(s)
- _____ Copy of DEA(s)
- _____ Copy of State Controlled Substance License(s) (if applicable)
- _____ Copy of Certificate of Professional Liability Insurance
- _____ Copy of Kansas Health Care Stabilization Fund or Nebraska Excess Liability Fund Coverage (if applicable)
- _____ NPI: National Provider Identifier Number
- _____ Government Issued Photo ID (i.e. driver's license, passport - **please do not fax – scan/mail only in color**)
- _____ Photo – any size (it will be scanned and resized as needed - **please do not fax – scan/mail only in color**)
- _____ Immunization Records (MMR, HepB, etc)
- _____ Influenza Vaccination (current year)
- _____ TB Test (within the last year including times and dates)
- _____ COVID-19 Vaccine (1st & 2nd Dose, Boosters)
- _____ Mandatory Reporting Certificate (**Iowa Applicants Only**)
- _____ Copy of Certificates of Previous 2 Years of CME's
- _____ SAFE Certification (**MO Applicants Only**)
- _____ Background Screening Authorization Form (Pages 1-3)