PHYSICIAN EMPLOYMENT APPLICATION

PHYSICIAN INFORMATION				
Last Name: (include suffix; Jr., Sr., III)	First:		Middle:	Degree(s):
Home Mailing Address:		City:		
		State:	Zip Code:	
Home Telephone Number:	Cell Phone Number:		E-Mail Address:	
Social Security Number	Are you eligible to work in the United States? Yes ☐ No ☐ If hired you will be required to provide legal documentation of your eligibility to work in the United States.			
Specialty:				

PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS	
Professional License/Registration/Cert Number:	Expiration Date:
Professional License/Registration/Cert Number:	Expiration Date:
Professional License/Registration/Cert Number:	Expiration Date:

UPIN:	NPI:	DEA: Expiration Date:

EDUCATION			
High School Name:	City:		State:
College or University Name:			Degree:
Mailing Address:	City:	State:	Zip Code:
College or University Name:			Degree:
Mailing Address:	City:	State:	Zip Code:

MEDICAL/PROFESSIONAL EDUCATION			
Medical/Professional School:		Graduation Date:	Degree
Mailing Address:	City:	State:	Zip Code:
Medical/Professional School:		Graduation Date:	Degree
Mailing Address:	City:	State:	Zip Code:

MASTER DEGREE PROGRAM OR POST GRADUATE EDUCATION				
Institution:	Address	City	State	Zip Code:
Program or Course of Study:				

RESIDENCIES – use extra sheets if necessary			
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From:	To:
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain)			
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From:	To:
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

FELLOWSHIPS – use extra sheets if necessary			
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:			
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:			

BOARD AND OTHER CERTIFICATIONS – use extra sheets if necessary		
Issuing Board/Entity and State Issued	Specialty	Expiration Date (if any)
Other Type:		Expiration
Other Type:		Expiration

WORK HISTORY

Chronologically list all work history activities since completion of professional training. Use extra sheets if necessary.

Name of Current Practice / Employer:	Contact Name:			Telephone Number: Fax Number:	
Mailing Address	City:	State:	Zip:	From:	To:
Name of Practice / Employer: Reason for Leaving:	Contact Name:			Telephone Number: Fax Number:	
Mailing Address:	City:	State:	Zip:	From:	To:
Name of Practice / Employer: Reason for Leaving:	Contact Name:			Telephone Number: Fax Number:	
Mailing Address:	City:	State:	Zip Code:	From:	To:

PEER REFERENCES

List at least **three** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. If you have been out of residency for a period of less than three years, one reference must be from the Program Director.

Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Cell Number: (Optional)	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Cell Number: (Optional)	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Cell Number: (Optional)	

PROFESSIONAL AFFILIATIONS
Please list membership in all professional societies. Use extra sheets if necessary. You need not disclose membership in professional organizations that may reveal information regarding race, color, creed, gender identity, religion, national origin, citizenship, ancestry, age, or the presence of any sensory, mental, or physical disability; marital status, veteran status, sexual orientation, or any other protected status.
Complete Name of Society:

Please answer all of the following questions. If you answer "yes" to any of the following questions in sections A through D, provide details on a separate sheet. ***If you attach additional sheets, sign and date each one.***

A.	**PROFESSIONAL SANCTIONS**		
1.	Have you ever been denied a license or had your license limited, suspended or revoked to practice in any state?	YES ☐	NO ☐
2.	Have your hospital or clinic staff privileges ever been limited, suspended, denied or revoked?	YES ☐	NO ☐
3.	Have you ever been involved in any other activity that would create doubt about your ability or right to practice?	YES ☐	NO ☐
4.	Have you ever had your Drug Enforcement Administration Certificate or prescribing privileges limited, suspended, or revoked by any state or federal agency?	YES ☐	NO ☐
5.	Is there anything preventing you from complying with any professional requirement?	YES ☐	NO ☐
6.	Have you ever been discharged or requested to resign from any employment?	YES ☐	NO ☐
7.	Have you ever been convicted of Medicare or Medicaid fraud?	YES ☐	NO ☐
B.	**CRIMINAL HISTORY** *Family Care Network requires that all clinical staff, as a condition of employment, undergo state and federal criminal background checks. Convictions will not necessarily exclude you from consideration for employment.*		
1.	Have you been convicted of a felony or released from prison within the past 10 years for an offense that may reasonably relate to the job duties of the position for which you are applying? If yes, explain fully.	YES ☐	NO ☐
C.	**AFFIRMATION OF ABILITIES**		
1.	Do you presently use any drugs illegally?	YES ☐	NO ☐
2.	Can you perform the essential functions of the job for which you are applying, with or without reasonable accommodation?	YES ☐	NO ☐
D.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY** If you answer "Yes" to any of the questions in this section, please provide details as specified on a separate sheet.		
1.	Are there any professional malpractice claims being asserted against you now?	YES ☐	NO ☐
2.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?	YES ☐	NO ☐

AUTHORIZATION AND RELEASE

By submitting this application, I understand and agree as follows:

1. I declare that I am qualified to perform all the duties of the position I am seeking. I attest to the accuracy, currency and completeness of the information provided in this application. I understand and agree that any misstatements in or omissions from the application and attachments hereto may constitute cause for denial of employment or summary dismissal or termination of employment.

2. I understand and acknowledge that, as an applicant for employment with Family Care Network, PLLC (FCN), FCN or designated agent will investigate the information in this application. By submitting this application, I agree to investigation of any and all statements contained in my application, my Curriculum Vitae, or furnished by me during the interview process. For example, I understand that FCN may contact my schools, former and current employers, and organizations which it feels may have information useful in making its hiring decision, whether specifically listed on my application or not.

3. If employed, I agree to take the necessary steps to minimize the risk of contracting or transmitting communicable diseases by complying with the company immunization policy and procedure.

4. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information regarding this application.

5. I authorize any person(s) contacted to provide responsive information to FCN. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with providing information, investigating and evaluating my application and qualifications, and I waive all legal claims against FCN and any representative of the organizations contacted or their respective agent(s) who act in good faith and without malice in connection with the investigation of this application.

6. I understand that this is only an application for employment and neither an offer of nor a contract of employment and no part of this application shall be construed as an offer of employment or an employment contract. If employed, I will be required to comply with all provisions in the FCN Employee Handbook, which may periodically be amended.

7. I understand that Family Care Network is a drug-free workplace and requires pre-employment drug testing for all potential employees.

I further understand that if employed by FCN, no representative of FCN, other than the President, has any authority to modify or change my status as an employee-at-will and that any such modification must be in writing signed by the President and refer to me by name in order to be enforceable.

☐ By checking this box, I acknowledge that I have read, understood, and agree to the above statements.

Name: _____

Date: _____