

COMMONWEALTH NEONATOLOGY, INC.

Business Office: 412 Libbie Avenue, Suite 4
Richmond, VA 23226

Date of Application: _____ Anticipated Start Date: _____

Applying for: Full-Time Part-Time

Personal Data

First Name _____ Middle Name _____ Last Name _____ MD/DO _____

Contact Information

Address _____ City _____ State _____ Zip _____

Phone Number _____ Pager _____ Cell Phone _____ Email Address _____

Please attach a resume listing education, professional organizations, associations, honors, research, certifications and publications.

Education and Certification:

If you are an international medical graduate: _____ ECFMG Number: _____ Date Issued: _____

Are you Pediatric board certified? Yes No If Yes, indicate month/year _____ Expiration: _____

Are you Neonatology Board Certified? Yes No If Yes, indicate month/year _____ Expiration: _____

Number of times boards taken until successful _____

Board eligible? Yes No

Work Eligibility

Are you authorized to work in the United States for any employer indefinitely? Yes No

Will you require sponsorship from Commonwealth Neonatology for an employment based visa? Yes No

How did you hear about Commonwealth Neonatology?

Recruiting Agency Name of Recruiter: _____ Publication Name of Publication: _____ Commonwealth Neonatology Employee Name of Employee: _____ Other Please specify: _____

Direct Mail Internet Residency Program Referral Self-Referral

Licensure

List all states where you are currently licensed or have previously been licensed or where you have currently or previously applied for licensure. Please include any additional information on a separate sheet.

1 State _____ Date Issued _____ License Number _____ Expiration _____

2 State _____ Date Issued _____ License Number _____ Expiration _____

Current DEA Number: _____

Please provide an explanation for any expired, lapsed, or suspended license: _____

Professional and Personal References

Please list (3) physicians in your specialty that have observed and evaluated your clinical performance, including your program director, if training was completed within the past two years.

	1	2	3
Physician Name:			
Title or Affiliation:			
Specialty:			
Address:			
City/State/Zip:			
Email Address:			
Phone:			
Fax:			

Please list three (3) other persons who know you well, maybe in training programs, current practice, or non-medical.

Name: _____ Address: _____

Phone: _____ Fax: _____ Email: _____

Name: _____ Address: _____

Phone: _____ Fax: _____ Email: _____

Name: _____ Address: _____

Phone: _____ Fax: _____ Email: _____

Practice Experience

Please start with the most recent practice or employment. International Medical Graduates, please include practice experience from medical school to U.S. Attach separate sheet if necessary.			
1	Employer	Dates of Employment:	
		From: (Mo/Yr.)	To: (Mo/Yr.)
	Address:	City	State Zip
	Supervisor	Phone	Fax
Reason for Leaving:			
2	Employer	Dates of Employment:	
		From: (Mo/Yr.)	To: (Mo/Yr.)
	Address:	City	State Zip
	Supervisor	Phone	Fax
Reason for Leaving:			
3	Employer	Dates of Employment:	
		From: (Mo/Yr.)	To: (Mo/Yr.)

Address:	City	State	Zip
Supervisor	Phone	Fax	
Reason for Leaving:			

Professional Liability Coverage

Have you ever insured with a state funded agency? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, which states:			
List ALL insurance carriers (including insurance companies, state-funded agencies, hospitals, clinics, employers, etc.) who have provided Professional Liability Coverage for you since completion of your graduate medical education. Attach separate sheet if necessary.			
1	Current Insurance Carrier	Agent	
	Address:	City	State Zip
	Phone Number	Fax	Policy Number Date of Coverage: From: To:
	Circle One: occurrence / claims made		Coverage Limits
2	Previous Insurance Carrier	Agent	
	Address:	City	State Zip
	Phone Number	Fax	Policy Number Date of Coverage: From: To:
	Circle One: occurrence / claims made		Coverage Limits

Professional Liability History

<p>If you answered "yes" to any of the Professional Liability questions below, please provide a detailed explanation below. Duplicate page 4 as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.</p> <p>If you have no Professional Liability claims to report, please sign and return this page.</p>	
Signature of Applicant	Date

Malpractice Actions – Professional Liability Claim Form

Applicant Name			
Claimant/Patient Name		Diagnosis	
Your involvement in the care (Attending, Consulting, etc.)		Your status in the case (sole defendant, co-defendant, ownership interest in provider practice named in suit, etc.)	
Allegations made against you			
Clinical Case Summary			
Patient Outcome			
Other Pertinent Details			
Date of Incident	Date Filed	Date Case Closed	Settlement Amount Paid on Your Behalf
Resolution of Case <input type="checkbox"/> Dismissed <input type="checkbox"/> Pending <input type="checkbox"/> Other _____ <input type="checkbox"/> Settlement out of Court <input type="checkbox"/> Arbitration _____ <input type="checkbox"/> Litigated <input type="checkbox"/> Mediation _____			
Professional Liability Insurer Name (if one was involved)		Insurer Address: (Street, City, State, Zip)	
Insurer Telephone Number		Insurer Policy Number	
I hereby declare that the above information is, to the best of my knowledge and belief, complete and accurate.			
Signature of Applicant		Date	
Print Name			

Practice Review

If you answer "yes" to any of the following questions, please provide a detailed explanation on separate sheet of paper.

1	Have you ever been denied a medical license of any type, whether full, limited, or temporary?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2	Has your medical license, DEA License, or other license entitling you to practice medicine in any jurisdiction been restricted, suspended or revoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3	Have any formal or written complaints been filed against you with any State Board of Medicine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4	Has your specialty or subspecialty board certification ever been denied, suspended, revoked or placed on probation, or is such an action pending now?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5	Is there any report filed concerning you on the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank?		
6	Has any investigation ever been taken against you by any healthcare carrier?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7	Have you ever been excluded from or sanctioned by Medicare or Medicaid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8	Did you leave an internship, residency, or fellowship without completing it?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9	Have you ever been denied initial or renewal membership, or been subjected to disciplinary proceedings in any facility or medical organization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10	Have your privileges or membership on the medical staff of any institution or medical organization ever been placed on probation, denied, suspended, diminished, revoked, not renewed, or have you ever been subject to a disciplinary action, completed or ongoing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11	Have you ever had your DEA Certification or prescribing privileges limited?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other

Should you be employed, do you plan to engage in any business or other employment? Yes No

If Yes, explain _____

List any languages that you could use in your work:

_____ Speak Read Write

_____ Speak Read Write

_____ Speak Read Write

Criminal Record Check

Have you ever been convicted of any crime, including motor vehicle violations other than speeding tickets?
(A conviction includes a plea, verdict or finding of guilt, regardless of whether sentence is imposed by the court.) Yes No

Are you presently on probation? Yes No

Are you presently on parole? Yes No

The existence of a criminal record does not automatically eliminate you from employment consideration.

Authorization to Release Information and Statement of Applicant

By signing this application, I hereby agree to cooperate fully with Commonwealth Neonatology, its medical staff, and its representatives during its investigation and processing of this application. I further agree to appear for all interviews, submit documents, written and/or oral evidence, or such other information as may be requested of me with regard to my application.

I hereby authorize Commonwealth Neonatology, its medical staff and its representatives to consult with, obtain and review oral or written information from such other persons or entities as they may deem appropriate, who may have information or evidence bearing on my competence, background, education, licensure, experience, character and ethical qualifications.

I also consent to and authorize the medical staff and representatives of Commonwealth Neonatology to obtain any oral or written information or records from any insurance carrier or vendor, Boards of Medicine, State licensing boards, any civil or criminal court, the Department of Motor Vehicles, or any other person or entities as they may deem appropriate, pertaining to any claims, suits or causes of action for professional negligence or medical malpractice.

I hereby release, acquit and forever discharge Commonwealth Neonatology, its medical staff and its representatives, and any and all other entities, vendors and persons who may furnish or submit written or oral information in connection with the investigations and processing of this application form and against any and all liability, claims, causes of action or demands for or by reason of any matter, cause of action, claims or demands for invasion of privacy, libel, slander and negligence which may arise from the submission, furnishing, discussion or use of any information described above, either oral or written.

I understand that the information furnished in this credentialing application will be provided to Commonwealth Neonatology's medical malpractice insurance carrier and will form the basis for the carrier's underwriting decision, and may be furnished to credentialing committees at hospitals with which Commonwealth Neonatology Contracts. I agree to notify Commonwealth Neonatology promptly of any material changes to my responses to this application.

I, the undersigned applicant, warrant that the information furnished in this application is true and correct and that no information of an adverse nature has knowingly been omitted or misstated. Any misrepresentation of facts on this Application is sufficient cause for summary dismissal from employment. No oral representation to the contrary has been made to me, and I further understand that no employee of Commonwealth Neonatology is authorized to make any such representation.

Signature of Applicant

Date

Print Name

Thank you for your interest in employment at Commonwealth Neonatology, Inc. We are always looking for committed and patient-focused professionals to grow with us. Your application will be considered without regard to age, race, sex, religion, color, national origin, disability, veteran status, marital status, or any other basis prohibited by local, state, or federal law.

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