920 Main Street, Suite 300
Kansas City, Missouri 64105
816-559-6333 or
800-821-5147 ext. 6333
Fax: 816-559-6394

Physician Application

Personal Information

Name					
	Last	First	Middle	Degree	- - Social Security Number

Home Address						
	Street	Apt #	PO Box #	City	State	Zip Code
Office Address						
	Street	Apt #	PO Box #	City	State	Zip Code

Contact Information			
	Home Phone	Office Phone	Fax
	Cellular	Pager	E-Mail

Education and Training

(Use Separate Sheet if Necessary)

Undergraduate Education	College or University/Location	Degree	Dates Attended
Graduate Education	College or University/Location	Degree	Dates Attended
Medical Education	College or University/Location	Degree	Dates Attended
Internship	Institution	Type	Dates Attended
	City/State	Completed?	☐ Yes ☐ No
Residency	Institution	Type	Dates Attended
	City/State	Completed?	☐ Yes ☐ No
Residency	Institution	Type	Dates Attended
	City/State	Completed?	☐ Yes ☐ No

Certifications

Primary Specialty	Certified ☐ Eligible ☐	Specialty	Name of Certifying Board
Secondary Specialty	Certified ☐ Eligible ☐	Specialty	Name of Certifying Board

FLEX Exam	Number	Exam Date	ECFMG	Number	Exam Date
National Board Exam	Number	Exam Date	State Board Exam	Number	Exam Date

Additional Certifications							
	ACLS	Instructor ☐	Provider ☐	NALS	Instructor ☐	Provider	☐
		Current? Yes ☐	No ☐		Current? Yes ☐	No	☐
	ATLS	Instructor ☐	Provider ☐	PALS	Instructor ☐	Provider	☐
		Current? Yes ☐	No ☐		Current? Yes ☐	No	☐

Licensure

Medical Licenses (Use separate sheet if necessary)	State	Number	Expiration Date	State	Number	Expiration Date
	State	Number	Expiration Date	State	Number	Expiration Date
Federal DEA & State Controlled Substance Reg	DEA State	Number	Expiration Date	Missouri BNDD	Number	Expiration Date
	DEA State	Number	Expiration Date	Other CSR State	Number	Expiration Date

Emergency Medicine Experience

Hospital	ED Type/Annual Census	From	To
Address	City/State/Zip		
Hospital	ED Type/Annual Census	From	To
Address	City/State/Zip		
Hospital	ED Type/Annual Census	From	To
Address	City/State/Zip		
Hospital	ED Type/Annual Census	From	To
Address	City/State/Zip		
Hospital	ED Type/Annual Census	From	To
Address	City/State/Zip		

Other Practice Experience

Employer	Position	From To
Address	City/State/Zip	Reason for Leaving
Employer	Position	From To
Address	City/State/Zip	Reason for Leaving
Employer	Position	From To
Address	City/State/Zip	Reason for Leaving
Employer	Position	From To
Address	City/State/Zip	Reason for Leaving
Employer	Position	From To
Address	City/State/Zip	Reason for Leaving

Additional Information

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

1.	Have you ever been denied a license to practice medicine?	☐ Yes	☐ No
2.	Has your license to practice medicine in any jurisdiction ever been limited, suspended, revoked, subjected to probationary conditions, or voluntarily surrendered, or are any of these proceedings presently pending?	☐ Yes	☐ No
3.	Have you ever been denied staff membership at any hospital or other health care facility with an organized medical staff?	☐ Yes	☐ No
4.	Have you ever been censured, reprimanded, disciplined, had privileges limited or suspended, been put on probation, or been requested to resign from the medical staff of any hospital, clinic, or other facility with an organized medical staff?	☐ Yes	☐ No
5.	Have you ever been censured, reprimanded, disciplined, had privileges limited or suspended, or put on probation during your medical school education and/or postgraduate training?	☐ Yes	☐ No
6.	Has your membership in a local, state or national professional society or organization ever been denied, revoked or suspended, or are suspension proceedings presently pending?	☐ Yes	☐ No
7.	Have you ever been notified by any medical organization or licensing or disciplinary agency of any current or pending charges or complaints against you?	☐ Yes	☐ No
8.	Have you ever lost board certification because of disciplinary action?	☐ Yes	☐ No
9.	Have you ever been denied a controlled substances registration certificate by the Drug Enforcement Administration (D.E.A.), State Bureau of Narcotics or other lawful authority concerned with controlled substances, or been censured, reprimanded, restricted, put on probation, had such registration certificate limited or revoked, or are any proceedings toward any of the above presently pending?	☐ Yes	☐ No
10.	Have you ever been convicted or pled guilty or nolo contendere in any criminal prosecution under the laws of any state or of the United States, for any offense reasonably related to the qualifications, functions, or duties of a physician; or for any offense an essential element of which is fraud, dishonesty, sexual misconduct, or an act of violence?	☐ Yes	☐ No
11.	Have you ever been subject to discipline for sexual misconduct or ever received counseling or training because of sexual misconduct?	☐ Yes	☐ No

12.	Have you ever been subject to a claim of unlawful discrimination or harassment?	☐ Yes	☐ No
13.	Have you ever been a defendant in a legal action involving professional liability (malpractice,) had a professional liability claim paid or settled on your behalf, or paid or settled such a claim yourself?	☐ Yes	☐ No
14.	Have you ever been denied professional liability insurance, or have you ever had a professional liability insurance policy cancelled?	☐ Yes	☐ No
15.	Have you ever been denied provider participation or had your participation limited, suspended, or terminated by any State Medicaid or Federal Medicare Program?	☐ Yes	☐ No
16.	Is there any reason why you cannot perform the essential job functions of an Emergency Medicine Physician with or without reasonable accommodation?	☐ Yes	☐ No
17.	Do you have knowledge of any matters that may interfere in any way with your obtaining hospital medical staff privileges in Emergency Medicine?	☐ Yes	☐ No

References

1.	Name	Address	Office Phone
	Relationship	City/State/Zip	Other Phone
2.	Name	Address	Office Phone
	Relationship	City/State/Zip	Other Phone
3.	Name	Address	Office Phone
	Relationship	City/State/Zip	Other Phone
4.	Name	Address	Office Phone
	Relationship	City/State/Zip	Other Phone

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AUTHORIZATION, RELEASE AND ACKNOWLEDGEMENT

EMS, LLC (EMS) its affiliates, employees, and representatives, collectively referred to as "EMS," are hereby authorized to request and obtain any information from any party EMS deems appropriate in connection with evaluating, verifying, and/or in any way facilitating my application and credentialing with EMS.

I hereby release EMS and any other individuals or entities providing such information from any and all liability or claims of any nature in connection with the information furnished in this Application. I further consent to the release of information obtained to EMS' client hospitals and/or health care providers.

I understand and agree that I will not have access to this information and I waive any right of access to such information, except as may be required by Law or a valid Court Order.

A copy of this authorization may be provided to each individual, hospital, organization, or other entity where information concerning my qualifications for the practice of medicine is sought, and shall remain in effect until specifically revoked in writing by me. A photocopy or facsimile of the Authorization/Release shall be as binding as the original.

I represent that the information provided in or attached to this Application is accurate and complete.

I understand that my signature is required to complete this application. **Stamped signatures are not acceptable.**

______________________________ ______________
Physician's Signature Date

____
Physician's Name (Please Print)