Keystone Collaborative Staffing

Employment Application

Anesthesiology & Pain Medicine

KEYSTONE COLLABORATIVE STAFFING

This form should be typed or **legibly printed in black ink**. If additional space is needed, attach additional sheets and reference the question(s) being answered.

Current copies of the following documents must be submitted with this application:

(all are required for MDs, DO's and other healthcare practitioners

* State professional Licenses
* Face Sheet of Professional Liability Policy or Certificate
* DEA Certificates
*ECFMG (if applicable)
* Curriculum Vitae (chronological beginning with professional education)

****All sections must be completed in their entirety. A curriculum vitae is not a substitute****

SECTION I: PERSONAL PROFILE			
Name:	☐ MD ☐ DO ☐ CRNA	Gender	☐ M ☐ F
Home Street Adress:			
City:	State:	Zip:	
Phone:		Cell:	
Date of Birth:	Place of Birth:		
SS #		Citizenship:	
Visa Status (if Not US Citizen):	Visa/Alien Number:		

SECTION II: EDUCATION		
Under-Graduate & Post-Graduate Education (list all schools attended)		
Name of University:		
Location:		
Education Type: ☐ Undergraduate ☐ Graduate ☐ Other	Major:	
Degree earned and date degree conferred:		
Dates of Attendance:		
Reason for departure if degree program not completed:		
Name of University:		
Location:		
Education Type: ☐ Undergraduate ☐ Graduate ☐ Other	Major:	
Degree earned and date degree conferred:		
Dates of Attendance:		
Reason for departure if degree program not completed:		

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Under-Graduate & Post-Graduate Education (list all schools attended)			
Name of University:			
Location:			
Education Type: ☐ M D ☐ D O ☐ CRNA		Date Conferred:	
Dates of Attendance:			
Reason for departure if degree program not completed:			
Under-Graduate & Post-Graduate Education (list all schools attended)			
Name of University:			
Location:			
Education Type: ☐ M D ☐ D O ☐ CRNA		Date Conferred:	
Dates of Attendance:			
Reason for departure if degree program not completed:			
Internship			
Specialty:			
Name of Program/Institution:			
Complete address:			
City:	State:	Zip:	
Program Director:	Contact #:		
Dates Attended:	Date Graduated:		
Residency (list all progams attended)			
Specialty:			
Name of Program/Institution:			
Complete address:			
City:	State:	Zip:	
Program Director:	Contact #:		
Dates Attended:	Date Graduated:		
Specialty:			
Name of Program/Institution:			
Complete address:			
City:	State:	Zip:	
Program Director:	Contact #:		
Dates Attended:	Date Graduated:		
Specialty:			
Name of Program/Institution:			
Complete address:			
City:	State:	Zip:	
Program Director:	Contact #:		
Dates Attended:	Date Graduated:		

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FELLOWSHIPS (list all programs attended)		
Specialty:		
Name of Program/Institution:		
Complete address:		
City:	State:	Zip:
Program Director:	Contact #:	
Dates Attended:	Date Graduated:	

Specialty:		
Name of Program/Institution:		
Complete address:		
City:	State:	Zip:
Program Director:	Contact #:	
Dates Attended:	Date Graduated:	

Gaps in Training and/or Medical Education: **For any of the above training programs please detail any reason for departure if degree not completed: (attach separate statement as needed)**

American Specialty Board Certification(s)		
Certification Board:	Date of issue/Recert:	Exp Date (mo/yr):
Certification Board:	Date of issue/Recert:	Exp Date (mo/yr):
Certification Board:	Date of issue/Recert:	Exp Date (mo/yr):
ECFMG Number: (foreign medical graduates)		Exp date:

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Section III: Clinical References (Must provide at leat four (4) references who must have the same equivalent degree and one current physician supervisor if you are an Advanced Practitioner.

CLINICAL REFERENCE		
Last Name:	First Name:	Credentials (MD, DO, CRNA):
Phone Number:	Email address:	
Preferred Contact Method:		
CLINICAL REFERENCE		
Last Name:	First Name:	Credentials (MD, DO, CRNA):
Phone Number:	Email address:	
Preferred Contact Method:		
CLINICAL REFERENCE		
Last Name:	First Name:	Credentials (MD, DO, CRNA):
Phone Number:	Email address:	
Preferred Contact Method:		
CLINICAL REFERENCE		
Last Name:	First Name:	Credentials (MD, DO, CRNA):
Phone Number:	Email address:	
Preferred Contact Method:		
CLINICAL REFERENCE		
Last Name:	First Name:	Credentials (MD, DO, CRNA):
Phone Number:	Email address:	
Preferred Contact Method:		
CLINICAL REFERENCES		
Last Name:	First Name:	Credentials (MD, DO, CRNA):
Phone Number:	Email address:	
Preferred Contact Method:		

Section IV: Licensure and Certification			
List all present and past state medical licensures			
State:	License #:	Date issued:	Exp Date:
State:	License #:	Date issued:	Exp Date:
State:	License #:	Date issued:	Exp Date:
State:	License #:	Date issued:	Exp Date:
State:	License #:	Date issued:	Exp Date:
State:	License #:	Date issued:	Exp Date:
State:	License #:	Date issued:	Exp Date:
DEA Registration Number			
DEA State:	License #:	Date issued:	Exp Date:
DEA State:	License #:	Date issued:	Exp Date:
DEA State:	License #:	Date issued:	Exp Date:
DEA State:	License #:	Date issued:	Exp Date:
CDS State:	License #:	Date issued:	Exp Date:
CDS State:	License #:	Date issued:	Exp Date:
ACLS/ATLS/BLS/NALS/PALS (i.e., Fluoroscopy, Radiography, etc.)(Attach Certificate if Applicable)			
ACLS Exp Date (mo/yr):	BLS Exp Date:	PALS exp:	

SECTION V: Military Service			
Military Service			
Branch:	Dates of Service:		
Brief description of job performed: Type of Discharge:			
Do you have any additional obligation to the military or federal government?		☐ No	☐ Yes
(Explain):			

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SECTION VI: Disclosure Questions Please answer all of the following questions. If your answer to any of the following questions is **"Yes", provide details as specified on a separate sheet.** If you attach additional sheets, sign and date each sheet.

PROFESSIONAL SANCTIONS

1. Have you ever been, or are y ou now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited sanctioned, placed on probration, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn or failed to proceed with an application for any of the following in ordeer to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?

	NO	YES
*License to practice any profession in any jurisdiction		
*Other professional registration or certification in any jurisdiction		
*Specialty or subspecialty board certification		
*Membership on any hospital medical staff		
*Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.		
*Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or public program		
*Professional society membership or fellowship		
*Participation/membership in an HMO, PPO, IPA, PHO or other entity		
*Academic Appointment		
*Authority to prescribe controlled substances (DEA or other authority)		
2. Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		
3. Have you been found by a state professional disciplinary board to have commited unprofessional conduct as defined in applicable state provisions?		
4. Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		

CRIMINAL HISTORY

	NO	YES
1. Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		
* Do you have notice of any such anticipated charges?		
* Are you currently under governmental investigations?		

AFFIRMATION OF ABILITIES		
	NO	YES
* Do you presently use drugs illegally?		
* Do you have, or have you had in the last five years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.		
*Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		

LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section, please document in Section VIII. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)		
	NO	YES
*Have allegations or claims have been made against you at any time where you were individually named in the claim or lawsuit?		
* Are there any such claims being asserted against you now?		
* 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)?		
* Are any of the privileges that you are requesting not covered by your current malpractice coverage?		

☐ **I warrant that all the above statements made on this form and any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.**

VIII. Professional Liability Action Detail		
Date of Claim:	**Location of Incident:**	**Liability Insurance at time of Incident:**
Amount Paid:	**Contact Number:**	
Outcome of Case:		
Detailed Description:		

☐ **I warrant that all the above statements made on this form and any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.**

VII. ATTESTATION
I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial or summary dismissal. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name Here: _____

Signature: _____ Date: _____