

Dear Provider:

Thank you for your interest in Locum Leaders, your premier locum tenens agency. Locum Leaders provides A++ rated occurrence malpractice insurance through Med Pro. Please complete this entire application and we will start our internal credentialing process. If additional space is needed, please attach separate pages. All credentialed providers will be called first and receive priority on any open jobs.

Please enclose the following documents with your application.

- Curriculum Vitae (Month and Year format throughout with time gap explanations)
- References – Please complete the enclosed reference forms (Top Portion Only)
Please include five names of references who can attest to your clinical skills, rapport with patients and co-workers, and professional past, and that had contact with you in the last two years.
- Signed Release and Authorization
- Medical School Diploma
- Internship, Residency and Fellowship Certificates
- Board Certification or Board Eligibility Letter
- All State Medical Licenses and State Controlled Substance Permits, if applicable
- ECFMG Certificate, if applicable
- DEA
- Current CMEs
- BLS, BCLS, ACLS, ATLS, PALS, NRP, and TEE if available
- Previous Certificate of Insurance, if available
- Case Logs, if available
- Copies of immunization records and TB screening records (PPD and Chest X-Ray, if applicable)
- Medicaid, Medicare, NPI and CAQH number, if available
 - If you do not have an NPI number, please apply at <https://nppes.cms.hhs.gov>
- Information on any malpractice claim regardless of whether the claim was dismissed, settled out of court, pending, or judgment
- W-9
- Provider Services Agreement

I attest the information provided by me on this page is true and accurate.

Name: _____ Initials: _____ Date: _____

GENERAL INFORMATION				
LAST NAME	FIRST NAME	MIDDLE	MAIDEN	DEGREE (MD or DO)
HOME ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	WORK PHONE	PAGER	EMAIL
EMERGENCY CONTACT		RELATIONSHIP	PHONE (CELL PREFERRED)	EMAIL IF AVAILABLE
NPI #	MEDICARE #	MEDICAID #	CAQH # IF KNOWN	ARE YOU CREDENTIALLED WITH THE VA? YES _____ NO _____
SOCIAL SECURITY #	DATE OF BIRTH	FEDERAL TAX ID #		
WILL YOU BE CONTRACTING WITH LOCUM LEADERS AS A CORPORATE ENTITY? YES _____ NO _____ IF YES, NAME OF ENTITY _____				
ARE YOU AUTHORIZED TO WORK IN THE UNITED STATES? YES _____ NO _____			SPECIALTY	
HEALTH STATUS				
The below questions are to assist you in placement, since this information will be required in the client's credentialing process. The answers will not eliminate us from submitting you to our client.				
Have you ever abused alcohol or drugs? If yes, please explain below:			YES _____ NO _____	
Do you need any special accommodations to perform the essential functions of your assignment? If yes, please explain below:			YES _____ NO _____	

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MILITARY SERVICE						
BRANCH OF SERVICE			TYPE OF DISCHARGE		DATES OF SERVICE – MONTH/YEAR / - /	
EXAMS AND CERTIFICATIONS						
____ USMLE ____ NATIONAL BOARD		IF STATE EXAM, WHICH STATE?		ECFMG #		ISSUE DATE
____ FLEX ____ STATE EXAM						EXP. DATE
BLS # AND EXP. DATE	BCLS # AND EXP. DATE	ACLS # AND EXP. DATE	ATLS # AND EXP. DATE	PALS # AND EXPIRATION DATE	NRP # AND EXP. DATE	TEE # AND EXP. DATE
EDUCATION AND TRAINING						
COLLEGE/UNIVERSITY				DEGREE	FROM	MONTH
						YEAR
ADDRESS			CITY	STATE	TO	MONTH
						YEAR
MEDICAL / OSTEOPATHIC SCHOOL				DEGREE	FROM	MONTH
						YEAR
ADDRESS			CITY	STATE	TO	MONTH
						YEAR
PG I – INTERNSHIP – FACILITY NAME				SPECIALTY	FROM	MONTH
						YEAR

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ADDRESS	CITY	STATE	TO	MONTH	YEAR
PG II – RESIDENCY – FACILITY NAME		SPECIALTY	FROM	MONTH	YEAR
ADDRESS	CITY	STATE	TO	MONTH	YEAR
PG III – RESIDENCY – FACILITY NAME		SPECIALTY	FROM	MONTH	YEAR
ADDRESS	CITY	STATE	TO	MONTH	YEAR
PG IV OR FELLOWSHIP – FACILITY NAME		SPECIALTY	FROM	MONTH	YEAR
ADDRESS	CITY	STATE	TO	MONTH	YEAR

BOARD CERTIFICATIONS

NAME OF SPECIALTY BOARD	CERTIFIED ___ YES ___ NO	DATE	RECERTIFIED ___ YES ___ NO	DATE
NAME OF SPECIALTY BOARD	CERTIFIED ___ YES ___ NO	DATE	RECERTIFIED ___ YES ___ NO	DATE

If Board Eligible, please include a letter stating Board Eligibility from the Board.
If you are scheduled to take the exam, please list the date you taking the exam. Date:

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Name: _____ Initials: _____ Date: _____

LICENSES AND CONTROLLED SUBSTANCE PERMITS						
STATE	LICENSE NUMBER	DATE ISSUED	EXPIRATION DATE	CONTROLLED SUBSTANCE PERMIT NUMBER	DATE ISSUED	EXPIRATION DATE
DEA				HAVE YOU COMPLETED FCVS? ____ YES ____ NO		
PLEASE LIST ALL INACTIVE LICENSES						
PLEASE LIST ALL PENDING LICENSES				ARE YOU WILLING TO LICENSE? ____ YES ____ NO		
HOSPITAL/FACILITY AFFILIATIONS						
HOSPITAL / FACILITY				CITY		STATE
TYPE OF PRIVILEGES				DATES – MONTH/YEAR / - /		
HOSPITAL / FACILITY				CITY		STATE
TYPE OF PRIVILEGES				DATES – MONTH/YEAR / - /		
PROFESSIONAL LIABILITY INSURANCE						
CARRIER		ADDRESS		CITY		STATE ZIP CODE
POLICY #		POLICY LIMITS		START DATE		EXPIRATION DATE
CARRIER		ADDRESS		CITY		STATE ZIP CODE
POLICY #		POLICY LIMITS		START DATE		EXPIRATION DATE

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DISCIPLINARY ACTIONS AND PROFESSIONAL LIABILITY	
HAVE YOU EVER BEEN CONVICTED OF A FELONY?	___ YES ___ NO
HAVE YOUR HOSPITAL PRIVILEGES EVER BEEN LIMITED, SUSPENDED, DENIED OR REVOKED?	___ YES ___ NO
HAVE ANY OF YOUR STATE MEDICAL LICENSES OR DEA EVER BEEN LIMITED, SUSPENDED, DENIED OR REVOKED?	___ YES ___ NO
HAVE YOU EVER WITHDRAWN AN APPLICATION FOR A STATE MEDICAL LICENSE, DEA, OR APPLICATION FOR MEDICAL STAFF?	___ YES ___ NO
HAVE YOU EVER BEEN DISCIPLINED BY A HOSPITAL, CLINIC, TRAINING PROGRAM OR GOVERNMENT AGENCY?	___ YES ___ NO
HAVE YOU EVER BEEN INVESTIGATED BY MEDICAID OR MEDICARE?	___ YES ___ NO
HAVE YOU EVER BEEN DENIED PROFESSIONAL LIABILITY COVERAGE?	___ YES ___ NO
DO YOU HAVE ANY PAST, PRESENT OR PENDING JUDGMENTS, SETTLEMENTS, OR CLAIMS IN PROFESSIONAL LIABILITY THAT HAVE EVER BEEN MADE AGAINST YOU? IF YES, PLEASE LIST DETAILS BELOW INCLUDING AMOUNTS, DATES AND ANY SUPPORTING DOCUMENTATION OR EXPLANTATIONS.	___ YES ___ NO
IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN BELOW.	

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Release and Authorization

The information I have given in this document is true and correct to the best of my knowledge and is subject to validation by Locum Leaders. If any of the information set forth in this document changes, I will notify Locum Leaders of such changes. I understand that any false statements, misrepresentations or omissions on this document may justify refusal or termination of an engagement with Locum Leaders.

I authorize the individuals, schools, and employers listed above to provide Locum Leaders and its authorized agent or representatives with any information that Locum Leaders requests. I release Locum Leaders and any of its authorized agents or representatives from liability for requesting this information or for using this information. I release any individual, school, or employer providing such information from liability for issuing/disclosing this information.

I also authorize Locum Leaders or any of Locum Leaders' authorized agents to obtain and release any documents necessary to assist with licensing or credentialing. I will provide these documents as requested and authorize Locum Leaders or any of Locum Leaders' authorized agents to obtain these documents from any source, including, but not limited to, state licensing boards, the American Board of Medical Specialties, the Federation of State Medical Boards, the NPDB, the American Medical Association, all government agencies, medical schools and training programs, hospitals, personal references, and physicians. These documents include, but are not limited to, CV, Locum Leaders' Independent Contractor Information Sheet, references, licenses, DEA, education, training, performance, military history, work history, NPI, Medicare and Medicaid numbers, malpractice claims, CMEs, immunization records, previous certificate of insurance, and case logs. This written and oral information can be shared with any facility including, but not limited to, hospitals, clinics, groups, CVOs, and state licensing boards. I release Locum Leaders and any of Locum Leaders' authorized agents from liability or damages that may result from the release of any of the above information.

I hereby authorize Locum Leaders and any of its representatives or agents, to disclose any information pertaining to my engagement with Locum Leaders. I hereby waive any and all rights and claims against Locum Leaders, and any of its representatives or agents, for divulging, disclosing, or providing information during my engagement or after my engagement terminates, about my engagement with Locum Leaders in response to any request for references or request for information by any entity.

I agree that references obtained by Locum Leaders or any of Locum Leaders authorized agents will not be released to me without the written consent of the reference source, unless otherwise required by law. Locum Leaders may conduct background checks on me to determine whether I have had a prior criminal conviction. I hereby authorize Locum Leaders and any of its representatives or agents, to receive any criminal history information pertaining to me which may be in the files of any federal, state, or local criminal justice agency. I hereby waive any and all rights and claims against Locum Leaders, and any of its representatives or agents, for seeking, gathering, and using such information. This release and authorization is ongoing until revoked in writing by me.

Printed Name: _____ Signature: _____

Social Security #: _____ Date of Birth: _____

Specialty: _____ Date: _____

I attest the information provided by me on this page is true and accurate.

Name: _____ Initials: _____ Date: _____

Reference Form

Name of Independent Contractor: _____

Specialty of Independent Contractor: _____

Address of Independent Contractor: _____

References obtained by Locum Leaders or any of Locum Leaders authorized agents will not be released to the Independent Contractor without the written consent of the reference source, unless otherwise required by law. The person who signs this form may not be related to the Independent Contractor by blood, marriage, or adoption. Reference source attests he/she has worked with the Independent Contractor in the last two years.

Name of Reference: _____ Specialty of Reference: _____

Address of Reference: _____

Phone of Reference: _____ Fax of Reference: _____

THE BELOW IS TO BE COMPLETED BY THE REFERENCE SOURCE:

How long have you known the Independent Contractor ? _____

In what capacity are you acquainted with the Independent Contractor? _____

Have you ever received reports of poor medical practice by the Independent Contractor, or have you discussed concerns you had about the Independent Contractor's practice with medical staff officers at a hospital?	YES	NO
	_____	_____

Have you ever received reports of poor relationships between the Independent Contractor and patients or other members of hospital staff?	_____	_____
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Should we know about anything that might come up, while credentialing the Independent Contractor ?	_____	_____
--	-------	-------

Are you aware of any past or pending malpractice claims against the Independent Contractor?	_____	_____
---	-------	-------

If you answered yes to any above questions, please provide an explanation below.

Please write any additional comments below.

Do you recommend the Independent Contractor for locum tenens assignments with Locum Leaders and Locum Leaders' clients?	YES	NO
	_____	_____

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