



**Postgraduate Training:**

From: \_\_\_\_\_ to: \_\_\_\_\_  
Hospital/Program: \_\_\_\_\_  
Program Director: \_\_\_\_\_  
Program Chairman: \_\_\_\_\_

From: \_\_\_\_\_ to: \_\_\_\_\_  
Hospital/Program \_\_\_\_\_  
Program Director: \_\_\_\_\_  
Program Chairman: \_\_\_\_\_

**Fellowship (If Applicable):**

From: \_\_\_\_\_ to: \_\_\_\_\_  
Hospital/Program: \_\_\_\_\_  
Program Director: \_\_\_\_\_  
Program Chairman: \_\_\_\_\_

**USMLE (If Applicable):**

Step I \_\_\_\_\_ Date Passed      Step II \_\_\_\_\_ Date Passed      Step III \_\_\_\_\_ Date Passed

Did you take any steps more than once?      Yes: \_\_\_\_\_ No: \_\_\_\_\_

**Please explain any gaps in dates from graduation of medical school and present:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical School Training in Foreign Country (If Applicable)**

Did you complete your medical school or medical training in a foreign country?

Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes provide your ECFMG Certificate Number: \_\_\_\_\_

**Board Certification**

Are you Board Certified?  Yes  No If yes, name of Board: \_\_\_\_\_

Date of Certification: \_\_\_\_\_ Certification Number: \_\_\_\_\_

If not, are you Board Eligible?  Yes  No Target Date for Board Certification: \_\_\_\_\_

**Relevant Employment (List Most Recent):**

Dates of Employment: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
Position: \_\_\_\_\_  
Reason for Leaving: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
Position: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

**Military Service**

Branch: \_\_\_\_\_

Dates: Active & Reserve \_\_\_\_\_

Rank: \_\_\_\_\_

**Malpractice Coverage History**

Present Malpractice Insurance Carrier: \_\_\_\_\_  
Company Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Dates of Coverage: From \_\_\_\_\_ to \_\_\_\_\_

Previous Malpractice Insurance Carrier: \_\_\_\_\_  
Company Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Dates of Coverage: From \_\_\_\_\_ to \_\_\_\_\_

**Hospital Privileges (List Most Recent)**

Hospital: \_\_\_\_\_ Date Credentialed or Re-Credentialed: \_\_\_\_\_  
Category/Status:  Active  Courtesy  Consulting  Other \_\_\_\_\_

Hospital: \_\_\_\_\_ Date Credentialed or Re-Credentialed: \_\_\_\_\_  
Category/Status:  Active  Courtesy  Consulting  Other \_\_\_\_\_

Hospital: \_\_\_\_\_ Date Credentialed or Re-Credentialed: \_\_\_\_\_  
Category/Status:  Active  Courtesy  Consulting  Other \_\_\_\_\_

**Previous Related Work Experience (List Most Recent First)**

Hospital/Group \_\_\_\_\_ Locums Company: \_\_\_\_\_  
Nature of Assignment: \_\_\_\_\_  
Start of Assignment: \_\_\_\_\_ Late Date Worked: \_\_\_\_\_

Hospital/Group: \_\_\_\_\_ Locums Company: \_\_\_\_\_  
Nature of Assignment: \_\_\_\_\_  
Start of Assignment: \_\_\_\_\_ Late Date Worked: \_\_\_\_\_

Hospital: \_\_\_\_\_ Locums Company: \_\_\_\_\_  
Nature of Assignment: \_\_\_\_\_  
Start of Assignment: \_\_\_\_\_ Late Date Worked: \_\_\_\_\_

**Medical Licenses**

States where you are licensed: \_\_\_\_\_

License Number for Each State: \_\_\_\_\_

**Provider Numbers**

UPIN Number: \_\_\_\_\_ Individual NPI Number: \_\_\_\_\_

AL Medicare Provider Number: \_\_\_\_\_ AL Medicaid Provider Number: \_\_\_\_\_

Alabama Blue Cross Provider Number: \_\_\_\_\_

**Drug Registration/License Information**

Federal DEA Certificate Number: \_\_\_\_\_

Original Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

AL State Drug Certificate Number: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Please indicate all schedules currently held     2     2N     3     3N     4     5

Is this certification limited or restricted?     No     Yes

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**Professional References** (Colleagues who have worked with you extensively in professional capacity)

Name: _____	Title: _____
Organization: _____	Relationship: _____
Mailing Address: _____	
Phone Number: _____	E-Mail: _____

Name: _____	Title: _____
Organization: _____	Relationship: _____
Mailing Address: _____	
Phone Number: _____	E-Mail: _____

Name: _____	Title: _____
Organization: _____	Relationship: _____
Mailing Address: _____	
Phone Number: _____	E-Mail: _____

**Memberships in Medical Associations/Societies**

List National-State-County Medical Associations/Societies which you are a current member of:

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

(4) \_\_\_\_\_

## Questionnaire

**IMPORTANT:** If any of the following questions are answered "Yes," please provide an explanation for each answer. If any questions do not apply to you, please answer "No". Failure to check an answer or provide explanations for "Yes" responses may result in delay of application processing. All questions must be answered

### Education and Training

1. During your education, internship, residency, fellowship, preceptorship or additional training, as applicable were you ever disciplined, suspended, placed on probation, formally reprimanded, or asked to resign?  Yes  No

### License Information

2. Have you ever been disciplined, reprimanded, or fined by any state board of medical examiners, professional conduct board, or state or federal agency that disciplines physicians or allied health professionals?  Yes  No

3. Has your license to practice, in your profession, ever been denied, limited, suspended, revoked, or subject to probation or any conditions or limitations in any state?  Yes  No

4. Have you ever been disciplined, suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health plan program (for example, Medicare, Medicaid, CLIA, professional society or managed care organization) or is any such action pending?  Yes  No

5. Have you ever been the subject of any investigation by any private, federal, or state health program – or is any such action pending?  Yes  No

6. Have your Federal DEA and/or State Controlled Dangerous Substance (CDS) Certificate(s) ever been voluntarily or involuntarily limited, suspended, revoked, relinquished, or not renewed – or are proceedings currently pending?  Yes  No

### Insurance Information

7. Has your professional liability insurance coverage ever been terminated or modified by action of any insurance company?  Yes  No

8. Have you ever been denied professional liability insurance coverage or rated in a higher-than-average risk class for your specialty?  Yes  No

8. Have any professional liability suits, actions, or claims alleging malpractice ever been filed against you?  Yes  No

9. Are any professional liability suits, actions or claims currently pending against you?  Yes  No

10. Have any judgments ever been made against you in professional liability cases or claims, or have you ever entered into any settlements?  Yes  No

11. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?  Yes  No

12. Are you currently uninsured for professional liability staff (malpractice insurance) coverage?  Yes  No

### Hospitals and Other Affiliations

13. Has your medical membership or clinical privileges at any hospital or healthcare institution or organization ever been limited, suspended, revoked, not renewed, or subject to probationary or other disciplinary conditions, or have proceedings toward any of these ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?  Yes  No

14. Has your request for any specific clinical privileges been denied or granted with stated limitations (aside from ordinary or initial requirements of proctorship), or has such a denial or limitation been recommended by a medical staff or peer review committee to a governing board?  Yes  No

15. Have you ever had any previous or pending challenges to, or voluntarily or involuntarily relinquished any medical staff membership or clinical privilege(s), as the result of any investigation or disciplinary action?  Yes  No

16. Have you ever been court-martialed, sanctioned, reprimanded, or cautioned by a hospital or any other healthcare facility or military agency; been involuntarily terminated or forced to resign; or have you resigned voluntarily while under investigation or threat of sanction from a hospital or healthcare facility or any military agency?  Yes  No

### Board Certification

17. Has your Specialty Board certification or eligibility ever been denied, revoked, relinquished, not renewed, suspended, or reduced – or have any proceedings toward those ends been instituted?  Yes  No

### Practice History

18. Are there any gaps in your professional practice history?  Yes  No

### Health Status

19. Do you have or have you had a chemical dependency and/or substance abuse problem, treated or untreated?  Yes  No

20. During the last three years have you ever been under the influence of alcohol during working hours, or have you had a chemical dependency and/or substance abuse problem, treated or untreated?  Yes  No

21. Are you unable, with or without reasonable accommodation, to practice to the fullest extent of your license, qualification, and privileges without in any way posing a risk of harm to your patients?  Yes  No



## **Authorization**

I hereby give permission to Salient Hospitalist and/or its designee to request information regarding my professional credentials and qualifications from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had medical staff membership and/or clinical privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers.

The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I release and agree to hold harmless Salient Hospitalist and its affiliates to whom this information is given and their representatives, employees and agents from any and all liability for any damages, costs, and expenses which may result from the gathering or use of such information, as long as such release or use of information is done in good faith and without malice.

I hereby authorize the educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability carriers, other professional monitoring entities and present and past employers to submit information requested by Salient Hospitalist including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and suit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I hereby further release and agree to hold harmless Salient Hospitalist, their representatives, employees and agents from any and all liability for any damages which may result from providing this information, as long as such release or use of this information is done in good faith and without malice. I further agree the burden shall be upon me to prove such release was done in bad faith and with malice by a preponderance of evidence.

I agree that a photocopy or facsimile of this document with my signature may be accepted by any person or entity from which such information is sought with the same authority as the original and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request.

I represent that the information provided in or attached to this Application and the most current information provided to Salient Hospitalist is accurate and complete. I understand that a condition of this Application is that any misrepresentation, misstatement or omission from this Application, whether intentional or not, is cause for automatic and immediate rejection of this Application by Salient Hospitalist and may result in denial of my application or termination of my participation with Salient Hospitalist. I further understand that any misrepresentation, misstatement or omission from this Application, if discovered after participation has been awarded to me, may lead to immediate suspension or termination of my relationship. I agree to use my best efforts to inform Salient Hospitalist in writing within 30 days if there is any change in the information provided or the answers to questions on the Application as a result to developments subsequent to my signing this Application.

I warrant that I have the authority to sign this Application, on my behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I agree that submission of this Application does not constitute approval or acceptance of this application or me by Salient Hospitalist as a participating provider or independent contractor. I further agree that this application may only qualify as a "pre-application" under the rules of the entity.

I understand that if my application is rejected for reasons relating to my professional conduct or clinical competence, Salient Hospitalist may be required to report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank.

- I have reviewed and **AGREE** to this attestation statement
- I have reviewed and **DO NOT AGREE** to this attestation statement

I UNDERSTAND THAT THIS APPLICATION DOES NOT ENTITLE ME TO PARTICIPATION WITH SALIENT HOSPITALIST OR IN ANY HOSPITAL, HEALTH CARE ENTITY, OR HEALTH PLAN. The undersigned, being hereby warned that intentional or unintentional false statements and the like so made may jeopardize the validity of the application, declares that he/she is properly authorized to execute this application; and that all statements made of his/her own knowledge are true; and that all statements made on information and belief are believed to be true.

**Signature:**

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date of Signature

## DOCUMENTATION

### Documents needed (please attach):

1. Copy of Medical School Diploma
2. Copy of Internship, Residency, and Fellowship Certificates
3. Program Director Attestation re: Projected Completion Date (If in Residency)
4. Copy of USMLE Scores
5. Copy of Board Certification
6. Copy of Driver's License
7. Copy of Alabama Medical License (and other State Medical Licenses if applicable)
8. Copy of Alabama Controlled Substances Registration
9. Copy of DEA Certificate
10. Copy of ECFMG Certificate (if applicable)
11. Copy of ACLS/BCLS/ATLS/PALS Certification Card
12. AMA Recognition Award for CME
13. NPI Confirmation Letter
14. Certificate of Coverage for Professional Liability Insurance
15. Copy of current TB Skin Test
16. Passport style photo or send via email (as JPEG file)
17. Certified copy of birth certificate or copy of valid passport
18. Copy of marriage or divorce certificate verifying name change (if applicable)
19. Copy of Curriculum Vitae
20. Copy of IRS W-9 Form

**Please forward the completed application and copies of all information listed above to:**

Becky Lewis  
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101 1<sup>st</sup> Avenue NE, Suite 150  
Cullman, AL 35055  
(256) 734-7878 Office  
(888) 298-8524 Fax  
becky@salienthealthventures.com