Application for Medical Staff & Malpractice Insurance

10845 Olive Blvd Suite 200●St.Louis, MO ●63141
Office●855-994-1634 Fax●314.692.9927
www.kpslocums.com

IDENTIFYING INFORMATION

Last Name _____ **First Name** _____ **Middle Name**_____

Maiden Name _____ **Social Security #**_____ **Specialty** _____

Home Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone (___**)**_____ **Office Phone (**____**)**_____**Mobile Phone (**____**)**_____

Office Address _____**City** _____ **State** _____ **Zip** _____

Birthplace_____**Date of Birth**_____**/**____**/**_____**Citizenship**_____

Marital Status_____**Name of Spouse**_____**Email Address**_____

PREMEDICAL EDUCATION

College or University_____**Degree**_____**Honors**_____

City_____**State**_____**Country**_____**Dates Attended**_____**to**_____

MEDICAL EDUCATION

Medical School_____**Degree**_____**Honors**_____

Street Address_____**City**_____**State**_____**Zip**_____

Country_____**Date Attended**_____**to**_____

1st YEAR POST GRADUATE MEDICAL EDUCATION (Internship or PGY-1)

Facility_____**Date Attended**_____**to**_____

Street Address_____**City**_____**State**_____**Zip**_____

Country_____**Type of Internship**_____ **Program Director**_____

Program Director Phone (____**)**_____**Fax(**____**)**_____**Email**_____

RESIDENCY

Facility_____Date Attended _____to_____

Street Address_____City_____State_____Zip_____

Type of Residency_____Program Director_____

Director Phone (_____)_____Fax(_____)_____Email_____

FELLOWSHIP

Facility_____ Date Attended_____to_____

Street Address_____City_____State_____Zip_____

Type of Fellowship_____Director_____

Director Phone (_____)_____Fax(_____)_____Email_____

CERTIFICATION

Certified by (Name of Board)_____Dates Certified/Recertified_____

If not, # of times attempted_____ If not, Date intending to sit in_____Expiration Date_____

Subspecialty Board Certification (Name of Board)_____Dates Certified/Recertified_____

If not, # of times attempted_____ If not, Date intending to sit in_____Expiration Date_____

BLS/CPR	Yes	No	Expiration Date
ACLS	Yes	No	Expiration Date
PALS	Yes	No	Expiration Date
ATLS	Yes	No	Expiration Date
NALS/NRP	Yes	No	Expiration Date

MEDICAL PRACTICE (List all places that you have practiced in the last 5 years)

Place of Practice_____Street Address_____

City_____State_____Zip_____Phone(_____)_____Fax(_____)_____

Position Held_____Dates_____To_____

Place of Practice_____Street Address_____

City_____State_____Zip_____Phone(_____)_____Fax(_____)_____

Position Held_____Dates_____To_____

EXAMINATION/REGISTRATION/LICENSES

USMLE_____**Year**_____**Number of Times Taken**____**Part 1**_____**Part 2**_____**Part 3**_____

NBME/NBOME_____**Year**_____**Flex**_____**Year**_____**SPEX**_____**Year**_____

State Boards (States Taken in)_____

Medicare Provider Number_____**Medicaid Number**_____**State**_____**UPIN#**_____

Federal DEA Number_____**Date Issued**_____**Expiration Date**_____**NPIN#**_____

DEA State of Registration_____**ECFMG Issue Date**_____

International Medical Graduates Visa Status_____**Do you have a permanent ECFMG certificate?** _____

List All States in Which You Currently Are or Have Ever Been Licensed

State of License	License Number	Issue Date	Expiration Date	State Controlled Substance #	Issue Date	Expiration Date

PROFESSIONAL REFERENCES

Please list at least six professionals who are able to assess your professional skills, ethical character and ability to work cooperatively with others. All references must have worked with you in the past 18 months and can assess clinical skills. These references may be used in the submittal process to a client.

1. **Name**_____**Specialty**_____
   Address_____**City**_____**State**_____**Zip**_____
   Phone(_____)_____**Fax(_____)**_____**Email**_____
2. **Name**_____**Specialty**_____
   Address_____**City**_____**State**_____**Zip**_____
   Phone(_____)_____**Fax(_____)**_____**Email**_____
3. **Name**_____**Specialty**_____
   Address_____**City**_____**State**_____**Zip**_____
   Phone(____)_____**Fax(_____)**_____**Email**_____
4. **Name**_____**Specialty**_____
   Address_____**City**_____**State**_____**Zip**_____

Phone(____)_____Fax(_____)_____Email_____

5. Name_____Specialty_____

Address_____City_____State_____Zip_____

Phone(_____)_____Fax(_____)_____Email_____

6. Name_____Specialty_____

Address_____City_____State_____Zip_____

Phone(_____)_____Fax(_____)_____Email_____

CLAIMS HISTORY

Are you now or have you ever been involved, directly or indirectly, in a claim or suit arising out of the rendering or failing to render professional services?	Yes	No
Do you have knowledge of claims, potential claims or suits in which you may become involved including, without limitations, knowledge of any alleged injury arising out of the rendering or failure to render professional services which may give rise to a claim?	Yes	No
If "Yes" have these been reported to your present carrier? Complete the Claim Information Form for Each such claim, potential claim or suit.	Yes	No
Has any company refused coverage, cancelled or refused to renew any insurance?	Yes	No
Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit? If "YES" please complete below. If needed, please attach a separate sheet showing the following information for each claim.	Yes	No

Patients Name or Description_____Date of Treatment_____

Date of Claim_____ Dismissed _____Settlement_____Judgment_____Open/Reserve_____

Amount_____ Date Closed_____

Allegations_____

_____

_____

_____

_____

Carrier Handling Case/Attorney Contact Information_____

Patients Name or Description_____Date of Treatment_____

Date of Claim_____ Dismissed _____Settlement_____Judgment_____Open/Reserve_____

Amount_____ Date Closed_____

Allegations_____

_____

_____

_____

_____

Carrier Handling Case/Attorney Contact Information_____

RECORD OF PREVIOUS CARRIERS

Company & Address	Limit per Claim/Aggregate	Eff. Date & Exp. Date	Claims Made or Occurrence	Policy Number	Type of Coverage

GENERAL INFORMATION

Please provide documentation and/or National Practitioners Data Bank Report for all "Yes" answers.

Have you ever been convicted of, pled guilty or pled nolo contendere to a felony misdemeanor; including any charge related to the use of alcohol or narcotics?	**Yes**	**No**
Has a hospital suspended, restricted, or refused your staff privileges or have you voluntarily surrendered, limited or withdrawn your privileges anytime while under peer investigation?	**Yes**	**No**
Have you ever voluntarily surrendered or had a narcotics license suspended, revoked, or restricted?	**Yes**	**No**
Have you ever voluntarily surrendered, non-renewed or had a state license to practice medicine refused, suspended, revoked or had any disciplinary or advisory action taken?	**Yes**	**No**
Have you ever been denied a medical license or been denied certification by a specialty board?	**Yes**	**No**
Has there been any change in your specialty in the past five years? If "Yes" describe	**Yes**	**No**
Have you ever been, or are you currently, subject to sanctions by Medicare/Medicaid (HCFA/CMS)?	**Yes**	**No**
Have you ever been or are you currently being treated for alcoholism or narcotic addiction? If Yes, provide details of rehabilitation program, including dates of treatment. (See Impaired Physician Policy Below)	**Yes**	**No**
Are you currently being treated for a mental illness, which could affect your ability to function as a physician? If "Yes", provide details of rehabilitation program, including dates of treatment. (See Impaired Physician Requirements Below)	**Yes**	**No**

IMPAIRED PHYSICAN REQUIREMENTS

Please provide a treating physician's statement which must include the following:

- **The impaired practitioner's name**

- Date of Birth
- Date when the physician first treated the impaired practitioner for such diagnosis
- Whether the impaired practitioner is still under the treating physician's care and, if not, the date when the treating physician last treated the impaired practitioner for such diagnosis.
- Description of the treatment program
- Prognosis
- Description of any patient care procedure or activities which the impaired practitioner cannot or should not perform as a result of the impairment
- Any additional information that KPS Locums may deem necessary to assess the impaired practitioner's ability to provide patient care.

LOCUM TENENS DOCUMENTATION CHECKLIST

The following list of documents assists your representative while searching for and matching your qualifications and preferences with the best practice opportunity available. These documents are also utilized when submitting your credentials to our clients and when applying for hospital privileges and licensure.

- Application for Medical Staff and Malpractice Insurance form
- One photo copy of your current Curriculum Vitae (CV)
- One photo copy of your Medical School Diploma
- One photo copy of each of your Internship, Residency, and Fellowship certificates
- One photo copy of each of your Specialty Board Certificates
- One photo copy of your current state license card for each state in which you are licensed
- One photo copy of your ECFMG
- One photo copy of your DEA license
- One photo copy of each state controlled substance license (If applicable)
- One passport sized photo (preferred) and/or clear copy of your driver's license (may be required for privileging and/or licensing)
- One photo copy of CME's obtained during past 2 years
- Provider Agreement (when placed)

If available, please return all documents as soon as possible. Please note, KPS Locums requires receipt of all documentation before you can begin working at one or our assignments. If you have any questions about the information requested, please call your representative at 1-855-994-1634.

KPS locums

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The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of the application and the effective date of the insurance, the undersigned will immediately notify the company of such changes, and the company may withdraw or modify any outstanding quotations authorization or agreement to bind the insurance.

Signing of this application does not bind the applicant or the company to complete the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued, and it will be attached to and become a part of the policy.

All written statements and materials furnished to the company in conjunction with the application are hereby incorporated by reference into the application and made a part hereof.

Notice: In some states, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Signature of Applicant: _____

Date:_____

Release of Information

By making application to KPS Locums staff, I hereby authorize KPS Locums to make an inquiry of any references and institutions in which I have been enrolled or by whom I have been employed or extended privileges, as to my qualifications, ethics and character.

I further authorize any of the above persons or institutions to forward any and all information their records may contain about me, and agree to hold them harmless from any action by me for their acts.

_____ _____

Please print or Type Full Name **Signature**

_____

Date