



PHYSICIAN APPLICATION

1613 N. Harrison Parkway, Suite 200
Sunrise, Florida 33323
(800) 437-2672 • (954) 838-2371 • FAX (954) 851-1764
Web site www.sheridanhealthcare.com

Date of Application _____ Date Available for Employment _____
Specialty _____
Position of Interest _____ Full Time Part-Time
Geographic Preference _____
State(s) _____

PERSONAL INFORMATION *Please type or print in black ink.*



Name _____
Last First Initial Title (MD, DO)

Other Name _____
Last First Initial Title (MD, DO)

List any other name that you have been known by _____

Address _____ City _____ State _____ Zip _____

Home Tel. _____ Fax _____ Work Tel. _____

Cellular _____ Pager _____ E-mail _____

Date of Birth (MM/DD/YY) _____ Place of Birth _____ Social Security # _____ M or F _____

Drivers License State _____ License # _____ Expiration _____

Are you a citizen of the United States? Yes No Resident Alien Card # _____ Languages Spoken _____

Provide the name and address of someone we can contact in case of an emergency.

Name _____ Relationship _____ Telephone _____

Address _____ City _____ State _____ Zip _____

EDUCATION



All gaps in time exceeding 30 days must be accounted for during your educational training. Attach separate sheet if necessary.

PRE-MEDICAL

1. College/University _____

Address _____ City _____ State _____ Zip _____

Dates Attended (Month/Year) _____ to _____ Major _____ Degree _____

2. College/University _____

Address _____ City _____ State _____ Zip _____

Dates Attended (Month/Year) _____ to _____ Degree _____

MEDICAL EDUCATION *List all institutions ever attended. Attach separate sheet if necessary.*

1. College/University _____

Address _____ City _____ State _____ Zip _____

Dates Attended (Month/Year) _____ to _____ Degree _____

2. College/University _____

Address _____ City _____ State _____ Zip _____

Dates Attended (Month/Year) _____ to _____ Degree _____

LICENSURE *List all medical licenses held, active and inactive, in the United States and other countries. Attach separate sheet if necessary. Denote avenue of licensing (USMLE, FLEX, NBME, State Board, Reciprocity).*

State/Country	License Number	Avenue	Date Issued	Expiration Date	Current/Pending/Inactive
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

If Florida licenses, NICA member? Yes No

FEDERAL DEA REGISTRATION

1. DEA Registration# _____ Expiration Date _____ 2. DEA Registration # _____ Expiration Date _____
 3. DEA Registration# _____ Expiration Date _____ 4. DEA Registration# _____ Expiration Date _____

Does your Federal DEA Registration(s) reflect schedules 2, 2N, 3, 3N, 4 and 5? Yes No If the answer is "No", please explain on separate sheet.

STATE SUBSTANCE REGISTRATION

State _____ State Controlled Substance# _____ Expiration Date _____
 State _____ State Controlled Substance# _____ Expiration Date _____
 State _____ State Controlled Substance# _____ Expiration Date _____
 State _____ State Controlled Substance# _____ Expiration Date _____

PRACTICE EXPERIENCE

List professional experience in reverse chronological order. List all time since medical school not included in post-graduate training. Include military duty. All gaps in time over 30 days must be accounted for. Attach separate sheet if necessary.

1. Present _____ Telephone _____ Fax _____
 Address _____ City _____ State _____ Zip _____
 Director/Supervisor _____ (Month/Year) _____ to _____

2. Former _____ Telephone _____ Fax _____
 Address _____ City _____ State _____ Zip _____
 Director/Supervisor _____ (Month/Year) _____ to _____

3. Former _____ Telephone _____ Fax _____
 Address _____ City _____ State _____ Zip _____
 Director/Supervisor _____ (Month/Year) _____ to _____

4. Former _____ Telephone _____ Fax _____
 Address _____ City _____ State _____ Zip _____
 Director/Supervisor _____ (Month/Year) _____ to _____

HOSPITAL AFFILIATIONS *List all medical facilities where you have held privileges of any type. Attach separate sheet if necessary.*

1. Hospital _____ Telephone _____ Fax _____
 Address _____ City _____ State _____ Zip _____
 Chief of Service _____ (Month/Year) _____ to _____

HOSPITAL AFFILIATIONS *List all medical facilities where you have held privileges of any type. Attach separate sheet if necessary.*



2. Hospital _____ Telephone _____ Fax _____
 Address _____ City _____ State _____ Zip _____
 Chief of Service _____ (Month/Year) _____ to _____

3. Hospital _____ Telephone _____ Fax _____
 Address _____ City _____ State _____ Zip _____
 Chief of Service _____ (Month/Year) _____ to _____

4. Hospital _____ Telephone _____ Fax _____
 Address _____ City _____ State _____ Zip _____
 Chief of Service _____ (Month/Year) _____ to _____

5. Hospital _____ Telephone _____ Fax _____
 Address _____ City _____ State _____ Zip _____
 Chief of Service _____ (Month/Year) _____ to _____

PROFESSIONAL REFERENCES



List the names and addresses of four professional references from training programs and/or current associates who are not related to you. One must be a Chief of Service/Program Director or a physician of authoritative status. References should be directly familiar with your medical abilities and should have worked with you within the past three years.

1. Name _____
 Position _____
 Address _____
 City _____
 State/Zip _____
 Telephone _____
 Pager _____
 Fax _____
 E-mail _____

2. Name _____
 Position _____
 Address _____
 City _____
 State/Zip _____
 Telephone _____
 Pager _____
 Fax _____
 E-mail _____

3. Name _____
 Position _____
 Address _____
 City _____
 State/Zip _____
 Telephone _____
 Pager _____
 Fax _____
 E-mail _____

4. Name _____
 Position _____
 Address _____
 City _____
 State/Zip _____
 Telephone _____
 Pager _____
 Fax _____
 E-mail _____

Permission to contact references listed? Yes No
Permission to contact past employers? Yes No

May we contact your present employer? Yes No
If No, when? _____

If you answer "YES" to any of the following questions, you must complete the attached Professional Data Detail form.

YES NO

- 1. Have you ever been denied a medical license or ever received an intent to deny?
2. Have any disciplinary actions ever been initiated and/or are any now pending against you by any licensing board?
3. Has your license to practice in any jurisdiction ever been surrendered, limited, suspended, revoked, placed on probation, voluntarily/involuntarily relinquished or otherwise had conditions placed upon it?
4. If you have ever been employed by a military service, a hospital, an HMO or any other provider of healthcare services, was your employment ever terminated by the employer or were you asked to resign?
5. Have you ever been refused membership by a hospital staff, medical staff or other healthcare facility, or have you voluntarily withdrawn an application?
6. Has your request for any specific clinical privilege ever been denied or granted with stated limitations?
7. Have your privileges at any hospital or other healthcare facility ever been suspended, diminished, revoked or not renewed?
8. Have you voluntarily or involuntarily resigned from the staff of any hospital or healthcare facility?
9. Have you ever voluntarily or involuntarily surrendered a narcotics registration, a state substance registration, or has one ever been limited, suspended, revoked or disciplined?
10. Have you ever been denied membership or renewal thereof, or been reprimanded, censured or subjected to disciplinary action in any healthcare organization?
11. Have you ever been charged with a felony or misdemeanor, other than speeding or minor traffic violations?
12. Have you ever failed to complete a medical training program?
13. Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, governmental (foreign or domestic) insurance program, for example, Medicaid or Medicare?
14. Have you ever been the subject of an investigation by any private, governmental (foreign or domestic) agency concerning your participation in any private, governmental (foreign or domestic) health insurance program?
15. Have you ever been reprimanded, sanctioned, placed on probation or disciplined by any licensing board, any federal, state or local society, agency, governmental body, hospital, third party payor, specialty board, academic board or program?
16. Are you currently engaged in illegal use of controlled dangerous substances?
17. Do you have any impairment, limitations and/or restrictions that effect your ability to practice medicine with reasonable skill and safety?
18. Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you?
19. Are there any facts or circumstances in existence which could result in a positive response to any of questions 1 through 18 above or in the filing or institution of a claim for liability against you?
20. Are you interested in participating in industry sponsored research studies?
21. Do you have experience in industry sponsored clinical research trials? If yes, what therapeutic area and which sponsors have you worked with?

I certify that the above questions have been answered correctly and fully. Signature _____ Date _____

APPLICANT'S STATEMENT



SIGN HERE

I understand that I have the burden of providing full and complete information to Sheridan Healthcorp, Inc. and its affiliates and subsidiaries to demonstrate my qualifications and disclose any adverse information that has or may in the future affect my ability to practice, obtain privileges, accreditation or professional liability insurance. I understand and agree that any misstatement or omission in the application and/or interview will constitute grounds for denial of my application for employment and/or discharge. If any changes occur in the information I have provided in this application making that information no longer correct, complete and/or affecting my professional status, I understand and agree that it is my obligation to notify Sheridan Healthcorp, Inc. its affiliates and subsidiaries immediately of said occurrence. Failure to comply with these obligations may constitute ground for denial and/or discharge of employment with Sheridan Healthcorp, Inc. its affiliates and subsidiaries. I understand I have the right to review information obtained by Sheridan Healthcorp, Inc. its affiliates and subsidiaries during the primary verification process; this information is limited to data that I can obtain from the same primary sources utilized (i.e. state licensing boards, National Practitioner Databank). I do not have the right to review the information that is peer review protected. All request for review of information must be in writing, signed by me and submitted to the Credentialing Department. In the event that I discover erroneous information while reviewing data requested from the Credentialing Department, I will be afforded (30) calendar days from the receipt of the data in which to advise the Credentialing Department as to the correct information. I will be afforded an additional thirty (30) calendar days to correct the information with the appropriate agency(ies) and advise the Credentialing Department. I understand that I am required to abide by all rules, regulations, policies and procedures of Sheridan Healthcorp, Inc. its affiliates and subsidiaries.

Signature _____ Date _____

SIGN HERE



1613 N. Harrison Parkway, Suite 200
Sunrise, Florida 33323
(800) 437-2672 • (954) 838-2371 • FAX (954) 851-1764
Web site www.sheridanhealthcare.com

MALPRACTICE CLAIMS DESCRIPTION
(FILED, UNFILED, SETTLED OR DISMISSED WITH OR WITHOUT PAYMENT)

Name of Patient _____ Pt. DOB _____

Allegation _____

Your Relationship to Patient _____

Date of Incident _____ Location of Incident _____

Insurance Carrier _____ Additional Defendants _____

Claim Status Open Closed If closed, indicate method of closing Dismissal Settled Judgment

Date of Closing _____ Amount of Settlement or Judgment _____

Describe your care and treatment of the patient. If additional space is necessary, use the reverse side or attach additional sheets.
Your narrative must provide adequate clinical detail to allow proper evaluation by a peer review committee and include the following information.

Condition and Diagnosis at Time of Incident

Describe Treatment Rendered (Including Dates)

Condition of Patient Subsequent to Treatment (Including Dates)

I certify that answers given on the Malpractice Claims Description form are true and complete to the best of my knowledge.

Print Name _____

Specialty _____

Signature _____ Date _____





1613 N. Harrison Parkway, Suite 200
Sunrise, Florida 33323
(800) 437-2672 • (954) 838-2371 • FAX (954) 851-1764
Web site www.sheridanhealthcare.com

MALPRACTICE CLAIMS DESCRIPTION (FILED, UNFILED, SETTLED OR DISMISSED WITH OR WITHOUT PAYMENT)

Name of Patient _____	Pt. DOB _____
Allegation _____ _____ _____	
Your Relationship to Patient _____	
Date of Incident _____	Location of Incident _____
Insurance Carrier _____	Additional Defendants _____
Claim Status <input type="checkbox"/> Open <input type="checkbox"/> Closed If closed, indicate method of closing <input type="checkbox"/> Dismissal <input type="checkbox"/> Settled <input type="checkbox"/> Judgment	
Date of Closing _____	Amount of Settlement or Judgment _____
Describe your care and treatment of the patient. If additional space is necessary, use the reverse side or attach additional sheets. Your narrative must provide adequate clinical detail to allow proper evaluation by a peer review committee and include the following information.	
Condition and Diagnosis at Time of Incident _____ _____	
Describe Treatment Rendered (Including Dates) _____ _____	
Condition of Patient Subsequent to Treatment (Including Dates) _____ _____	
I certify that answers given on the Malpractice Claims Description form are true and complete to the best of my knowledge.	
Print Name _____	
Specialty _____	
Signature _____	Date _____
	



1613 N. Harrison Parkway, Suite 200
Sunrise, Florida 33323
(800) 437-2672 • (954) 838-2371 • FAX (954) 851-1764
Web site www.sheridanhealthcare.com

MALPRACTICE CLAIMS DESCRIPTION (FILED, UNFILED, SETTLED OR DISMISSED WITH OR WITHOUT PAYMENT)

Name of Patient _____ Pt. DOB _____

Allegation _____

Your Relationship to Patient _____

Date of Incident _____ Location of Incident _____

Insurance Carrier _____ Additional Defendants _____

Claim Status Open Closed If closed, indicate method of closing Dismissal Settled Judgment

Date of Closing _____ Amount of Settlement or Judgment _____

Describe your care and treatment of the patient. If additional space is necessary, use the reverse side or attach additional sheets.
Your narrative must provide adequate clinical detail to allow proper evaluation by a peer review committee and include the following information.

Condition and Diagnosis at Time of Incident

Describe Treatment Rendered (Including Dates)

Condition of Patient Subsequent to Treatment (Including Dates)

I certify that answers given on the Malpractice Claims Description form are true and complete to the best of my knowledge.

Print Name _____

Specialty _____

Signature _____ Date _____





1613 N. Harrison Parkway, Suite 200
Sunrise, Florida 33323
(800) 437-2672 • (954) 838-2371 • FAX (954) 851-1764
Web site www.sheridanhealthcare.com

MALPRACTICE CLAIMS DESCRIPTION
(FILED, UNFILED, SETTLED OR DISMISSED WITH OR WITHOUT PAYMENT)

Name of Patient _____ Pt. DOB _____

Allegation _____

Your Relationship to Patient _____

Date of Incident _____ Location of Incident _____

Insurance Carrier _____ Additional Defendants _____

Claim Status Open Closed If closed, indicate method of closing Dismissal Settled Judgment

Date of Closing _____ Amount of Settlement or Judgment _____

Describe your care and treatment of the patient. If additional space is necessary, use the reverse side or attach additional sheets.
Your narrative must provide adequate clinical detail to allow proper evaluation by a peer review committee and include the following information.

Condition and Diagnosis at Time of Incident

Describe Treatment Rendered (Including Dates)


Condition of Patient Subsequent to Treatment (Including Dates)

I certify that answers given on the Malpractice Claims Description form are true and complete to the best of my knowledge.

Print Name _____

Specialty _____

Signature _____ Date _____





1613 N. Harrison Parkway, Suite 200
Sunrise, Florida 33323
(800) 437-2672 • (954) 838-2371 • FAX (954) 851-1764
Web site www.sheridanhealthcare.com

PROFESSIONAL DATA DETAIL

If you have answered "YES" to any question(s) on page six of the application regarding Professional data, you must Complete this form. Be specific and include the following information

1. Type of event.
2. Date and place the event occurred.
3. Name each individual, including his/her title or designation, involved in the event.
4. Current status or outcome of the event.

If additional space is necessary, attach separate sheet.

COMMENTARY

Question Number _____

Question Number _____

I certify that answers given on the Professional Data Detail Form are true and complete to the best of my knowledge.

Print Name _____

Signature _____ Date _____





1613 N. Harrison Parkway, Suite 200
Sunrise, Florida 33323
(800) 437-2672 • (954) 838-2371 • FAX (954) 851-1764
Web site www.sheridanhealthcare.com

AUTHORIZATION AND RELEASE

I authorize Sheridan Healthcorp, Inc. its employees, officers, agents, directors, affiliates, managed companies and subsidiaries, to consult with the administrators and members of the medical staffs of other hospitals or institutions with whom I have been associated and with others, including, without limitation, governmental and professional organizations, past and present malpractice carriers, and educational institutions that may have information regarding my professional competence, character, and qualifications or other information about me.

I authorize Sheridan Healthcorp, Inc. its employees, officers, agents, directors, affiliates and subsidiaries to disclose to current, prior, or potential employers, hospitals, government and managed care payors making a reasonable inquiry, information relating to my qualifications, ability, criminal background check and character to practice medicine.

I release from liability Sheridan Healthcorp, Inc., its employees, officers, agents, directors, affiliates and subsidiaries for their acts performed in good faith, in connection with evaluating my application, credentials and qualifications. I release from any liability whatsoever, all individuals, entities and organizations who provide information to Sheridan Healthcorp, Inc., its employees, officers, agents, directors, affiliates and subsidiaries, in good faith, concerning my professional competence, ethics, character and other information about me and I consent to the release of said information.

Print Name _____

Signature _____ Date _____



SIGN HERE



1613 N. Harrison Parkway, Suite 200
Sunrise, Florida 33323
(800) 437-2672 • (954) 838-2371 • FAX (954) 851-1764
Web site www.sheridanhealthcare.com

REQUIRED DOCUMENTATION

ATTACH A COPY OF THE FOLLOWING APPLICABLE DOCUMENTS

- Current Curriculum Vitae – **All gaps in time exceeding 30 days must be documented.**
- Medical School Diploma
International Medical School Graduates – Have your diploma translated and notarized.
- ECFMG Certificate
- Fifth Pathway Certificate
- FLEX, NBME, USMLE, State Board Licensing Exam Certificate & score
- Internship, Residency and Fellowship certificates
- Evidence of Board Certification, Eligibility, Admissibility
- State Medical License(s) and Renewal Certificate(s)
- Current DEA Certificate(s)
- Current State Substance Registration(s)
- Three Current Letters of Recommendation addressed to Sheridan Healthcorp, Inc.
- Current Professional Liability Insurance Declaration Page
- Previous Professional Liability Insurance Declaration Page(s) for five years
- Occupational Licenses (County and Municipal)
- Current BLS, ACLS, ATLS, NRP, APLS, PALS Certification Card(s)
- Signed Authorization and Release Form
- Six Recent Passport Photos (write name on back of photos)
- Current Workers' Compensation Certificate
- Copy of Drivers License
- Copy of Alien/Naturalization Card, if applicable
- Copy of Social Security Card
- CME Certificates (for last two years)
- Completed Malpractice Claims Description Form
- Completed Professional Data Detail Form

Comments _____

Name _____ Date _____