Pacific Locums

Document Check List
For Locum Tenens

Please be sure the Application Packet is completed in its entirety. The Application Packet includes:

__ Completed Application

__ Consent and Release

__ Direct Deposit Authorization

__ W-9

In addition to the Application Packet, please provide the following Supporting Documents:

__ Current Curriculum Vitae
- Must include a complete chronology of activities detailed by MM/YY dates.
- Please provide an account for gaps in chronology over 30 days.
- If you are a locum tenens physician, your CV must reflect all assignments during the last five years.
- Please indicate on your CV the date it was last updated.

__ One copy each of all current State Medical License Cards

__ Copy of ECFMG Certificate (*if applicable*)

__ One copy of your Federal D.E.A Certificate

__ Copy of your medical malpractice (*if applicable*)

__ Copy of Driver's License

__ Copies of all current CPR cards (within the past year) ACLS, BLS, etc.

__ Copies of CMEs from the last 3 years

__ Current Photo

__ TB Test and Immunization Records
(TB Test must have been done within the last twelve months)

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LOCUM TENENS
APPLICATION PACKET

Please complete the application in its entirety. If a question **does not apply** to you, please **write N/A**.
If additional space is required in answering any section of the, attach all information on a separate sheet of paper.

IDENTIFYING INFORMATION

Name: Last, First, Middle Initial

Any Other Names by Which You Have Been Known

Primary Practice Specialty

Secondary Practice Specialty

NPI Number

Social Security Number

Degrees: MD ☐ DO ☐ MBBS ☐ OTHER (please specify:) ☐

Date of Birth*

Birth State/Province, State

Are you able to work legally in the United States? ☐ Yes ☐ No

If yes, please indicate the following: ☐ US Citizen ☐ Visa or Work Authorization

Other than English, list all languages you speak

PREFERRED ADDRESS

Address: Street/Apt or Unit#

Email Address

City/State/Zip Code/ Country

Home Phone Number

Work Phone Number

Mobile Phone Number

EMERGENCY CONTACT INFORMATION

Name

Relationship

Telephone Number

Address: Street/Apt#/Unit#

Alternate Number

MILITARY STATUS

Have you ever served in the United States Military? ☐ Yes ☐ No If yes, which branch? _____

Type of Discharge: _____

Are you a Disabled Veteran? _____

Veteran of the Vietnam Era? _____

Veteran (other)? _____ Please explain: _____

* Used for credentials verification purposes only. Pacific Locums does not discriminate on the bases of age or other factors.

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EDUCATION

Undergraduate: College or University | Degree | Honors

City/State | Dates Attended | Date of Graduation

Medical: College or University | Degree | Honors

City/State | Dates Attended | Date of Graduation

Internship: Hospital/Location | Type/Specialty

City/State | Dates Attended | Program Chair/Director

Residency: Institution | Type/Specialty

City/State | Dates Attended | Program Chair/Director

Residency: Institution | Type/Specialty

City/State | Dates Attended | Program Chair/Director

Fellowship or Preceptorship: Institution | Type/Specialty

City/State | Dates Attended | Program Chair/Director

Fellowship or Preceptorship: Institution | Type/Specialty

City/State | Dates Attended | Program Chair/Director

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BOARD CERTIFICATIONS

Name of Specialty Board	Certified?	Date (mm/yyyy)	Recertified?	Date (mm/yyyy)
_____	Y ☐ N ☐	_____	Y ☐ N ☐	_____
_____	Y ☐ N ☐	_____	Y ☐ N ☐	_____

If not board certified, have you been accepted to take a specialty examination? Y ☐ N ☐ Date Scheduled _____

If not board certified, how many times have you taken a specialty board examination and failed to pass? _____

PROFESSIONAL LICENSES Please list all current and inactive state medical licenses and state controlled substance permits.

State	License Number	Date Issued	Expiration Date	Controlled Substance Permit Number	Date Issued	Expiration Date
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

EXAMINATIONS & REGISTRATIONS

☐ USMLE ☐ Flex _____ _____ _____

☐ National Board ☐ State Exam In Which State Number of Attempts Date Last Taken?

_____ _____ _____ _____ _____

Medicare # Medicaid # UPIN # NPI # Federal DEA #

If you do not currently possess a DEA Registration, please explain here:

_____

Are you registered with the FCVS (Federation Credentials Verification Service)? Y ☐ N ☐

Do you have a complete FCVS profile? Y ☐ N ☐ If yes, packet ID# _____

Did you graduate from a medical school outside of the United States, Puerto Rico, or Canada? Please answer the following:

Do you have a permanent ECFMG certificate: Y ☐ N ☐ Did you do a Fifth Pathway? Y ☐ N ☐

ECFMG Certificate # _____

CERTIFICATION LIST

ACLS	_____ ISSUE DATE	_____ EXP. DATE	**NRP**	_____ ISSUE DATE	_____ EXP. DATE
BCLS	_____ ISSUE DATE	_____ EXP. DATE	**ALSO**	_____ ISSUE DATE	_____ EXP. DATE
ATLS	_____ ISSUE DATE	_____ EXP. DATE	**PALS**	_____ ISSUE DATE	_____ EXP. DATE

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PROFESSIONAL LIABILITY INSURANCE HISTORY List all carriers in the past five (5) years, you may include separate sheet, if necessary.

Current Carrier | Policy Number | Coverage Dates

Address | City, State | Coverage Limits | Phone Number

Carrier Name | Policy Number | Coverage Dates

Address | City, State | Coverage Limits | Phone Number

Carrier Name | Policy Number | Coverage Dates

Address | City, State | Coverage Limits | Phone Number

Carrier Name | Policy Number | Coverage Dates

Address | City, State | Coverage Limits | Phone Number

Carrier Name | Policy Number | Coverage Dates

Address | City, State | Coverage Limits | Phone Number

HOSPITAL AFFILIATIONS List all **current** hospital appointments and any held within the past five years. Include separate sheet, if necessary.

Hospital | Formerly Known As | Phone

Address | City/State/Zip Code | Country

Department/Service | Division Chief | Staff Category

Start Date (mm/yyyy) | End Date (mm/yyyy) | Percent of annual admissions/caseload

Hospital | Formerly Known As | Phone

Address | City/State/Zip Code | Country

Department/Service | Division Chief | Staff Category

Start Date (mm/yyyy) | End Date (mm/yyyy) | Percent of annual admissions/caseload

Hospital | Formerly Known As | Phone

Address | City/State/Zip Code | Country

Department/Service | Division Chief | Staff Category

Start Date (mm/yyyy) | End Date (mm/yyyy) | Percent of annual admissions/caseload

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PROFESSIONAL REFERENCES

Please list at least three colleagues with whom you have worked directly in the last twelve (12) months; at least two should be from an MD/DO.

If you are currently in residency or have graduated within the past three (3) years, we request that you provide the following professional references:

- Program / Residency Director
- Department Chairman
- An Attending physician during your residency
- If the Program Director and Department Chairman are one and the same, please list another physician who was an Attending physician during your residency.

For physicians with experience beyond three (3) years, professional references should include:

- Department Chairman – at hospital which you hold medical staff privileges
- Peer recommendation – Attending Physician
- Attending Physician – at hospital where you hold medical staff privileges

Last Name – MD/DO ____________ First ____________ Specialty ____________

Address ____________ City/State/Zip Code ____________ Country ____________

Facility ____________ Years Known ____________ Relationship ____________

Home Number ____________ Work Number ____________ Cell Number ____________ Fax Number ____________ Email Address ____________

Last Name – MD/DO ____________ First ____________ Specialty ____________

Address ____________ City/State/Zip Code ____________ Country ____________

Facility ____________ Years Known ____________ Relationship ____________

Home Number ____________ Work Number ____________ Cell Number ____________ Fax Number ____________ Email Address ____________

Last Name – MD/DO ____________ First ____________ Specialty ____________

Address ____________ City/State/Zip Code ____________ Country ____________

Facility ____________ Years Known ____________ Relationship ____________

Home Number ____________ Work Number ____________ Cell Number ____________ Fax Number ____________ Email Address ____________

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DISCLOSURE QUESTIONS
If you answer "Yes" to question #2 through #12, please provide a detailed explanation on a separate sheet of paper.

1. The essential function of a Locum Tenens physician is to provide a standard of care that is acceptable within his/her specialty. Are you capable of performing this function? Y ☐ N ☐

2. Have you ever been the subject of disciplinary or investigative proceedings or reprimanded by a governmental or administrative agency, hospital or professional association? Y ☐ N ☐

3. Have you ever had any State professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or voluntary surrender of same? Y ☐ N ☐

4. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation? Y ☐ N ☐
(a "yes" will not automatically disqualify you from consideration for placement)

5. Have you ever been denied a certificate by, or the privilege of taking an examination before, any state medical Board? Y ☐ N ☐

6. Have you ever been denied provider participation in, or terminated, sanctioned, penalized by or had to repay money to any state or federal Medicare/Medicaid program? Y ☐ N ☐

7. Have your hospital privileges and / or professional services ever been denied, revoked, suspended, refused, limited, placed on probation, or placed under and disciplinary action? Y ☐ N ☐

8. Have you resigned from a position in lieu of an investigation, or have ever been terminated from employment? Y ☐ N ☐

9. Have there been or are there any pending malpractice claims, judgments, suits, settlements, or notice of intent to commence action involving you and / or your medical practice? Y ☐ N ☐

10. Have you ever been convicted of an act committed in violation of any law or ordinance other than a traffic violation? Y ☐ N ☐

11. Do you have now or have you ever had any problems with or been treated for drug or alcohol dependency? Y ☐ N ☐

12. Have you ever been convicted of a violation of any federal or state narcotic law? Y ☐ N ☐
(a "yes" answer will not automatically disqualify you from consideration for placement)

13. Have you ever had any professional liability insurance company cancel, decline, refuse to renew, or accept only on special terms, their malpractice insurance? Y ☐ N ☐

14. Is there any other issue which should be disclosed that may have an adverse impact on your ability to deliver effective Locum Tenens service? Y ☐ N ☐

15. To your knowledge, has any information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? Y ☐ N ☐

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CONSENT AND RELEASE

I hereby give my consent and authorize Pacific Companies (PC), Pacific Companies' Manager, Pacific Locums (PL), and their authorized representatives to consult with the management and appointees of the medical staff of any and all hospitals, health care facilities or institutions with which I have been associated, and with others who may have information bearing on my professional qualifications, credentials, clinical competence, clinical privileges requested or presently granted, character, mental or emotional stability, physical condition, ethics, behavior or any other matter, as well as to inspect any and all records and documents that may be material to such questions.

I further give my consent to the above-described institutions and other with whom PC and PL consult, to disclose to PC and PL or their designated agents, such information as described above. I hereby release the above-described institutions and others from any and all liability arising from good faith disclosures, orally or in writing, of information, records or documents to PC and PL in response to an inquiry emanating from PC, PL or their authorized representatives. Upon request of PC and PL, I will execute a written confirmation of this Consent and Release to any institution or person from which PC and PL may request any of the above-described information. I further release PC, PL and their affiliates and representatives from any and all liability arising from the above-described disclosures to them or their representatives.

I realize that my refusal to sign this form constitutes a violation of the stated policy of PC and PL, and for that refusal I will not be considered for, and knowingly waive any possibility of permanent placement or locum tenens by PC and PL.

_____ _____

Signature Printed Name

_____

Date

PACIFIC Locums

Direct Deposit Authorization Form

☐ Accept Direct Deposit ☐ Decline Direct Deposit

I here by authorize **Pacific Locums** and its entities, hereinafter called **COMPANY**, to initiate credit entries and to initiate if necessary, adjustments for any credit entries in error to my checking and / or savings account indicated below at the depository named below. This authority is to remain in full force and effect until **COMPANY** has received written notification from me of its termination in such time and in such a manner as to afford **COMPANY** and Deposit Institution a reasonable opportunity to act on it.

Account Number _____

Routing Number _____

Checking or Savings? Checking ☐ Savings ☐

Name of Deposit Institution _____

City, State _____

Please attach a copy of a voided check.

If declining Direct Deposit, please complete the information below. Please allow 7 to 10 business days to receive check via standard delivery times with the United States Postal Service.

Candidate Name _____

Address where check is to be mailed:

Street Address _____

City/State/Zip _____

Phone Number _____

Social Security # _____

Candidate Signature _____

Date _____

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Exempt payee

☐ Other (see instructions) ▶

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.