# EMERGENCY MEDICINE CONSULTANTS, LTD

*6451 Brentwood Stair Road, Suite 200*
*Fort Worth, Texas 76112*
*Main (817) 496-9700*
*Toll Free (800) 569-0938*
*Fax (817) 507-1787*
*www.emdocs.com*

Management Service Organization for:

Texas Medicine Resources, LLP
Texas Physician Resources, LLP
TEMPEG, LLP
Pediatric Emergency Medicine Group, LLP

## PERSONAL INFORMATION

Full Name ______________________________________________________ MD ______
Last First Middle DO ______

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Driver's License # ____________________________ State ____________ Expiration Date ____________________

Do you currently have a professional association or other corporate entity formed? ☐ Yes ☐ No

If yes, Name:_______________________________________________ Tax ID#: ____________________

If no, please print your legal name for contract purposes: ______________________________________________

Are you a current Texas Medical Association member? ☐ Yes ☐ No

Marital Status ☐ Single ☐ Married Spouse ______________________________________

Emergency Contact: Name ____________________ Relationship ______________ Phone Number ________________

## OTHER CERTIFICATION

ACLS ☐ Yes ☐ No
Provider Expires____________

ACLS ☐ Yes ☐ No
Instructor Expires___________

ATLS ☐ Yes ☐ No
Provider Expires____________

ATLS ☐ Yes ☐ No
Instructor Expires___________

PALS ☐ Yes ☐ No
Provider Expires____________

APLS ☐ Yes ☐ No
Provider Expires___________

BLS ☐ Yes ☐ No
Provider Expires____________

Other __________ ☐ Yes ☐ No
Provider Expires___________

## REFERENCES

Please provide at least five (5) Peer References (four physicians and one nurse) of your same discipline who can attest to your clinical competence and work ethics. *Please note: Complete addresses, phone numbers, and e-mail addresses are required to ensure faster completion of your application.*

Name ________________________________________ Specialty/Title ________________________
Facility______________________________________ Home Phone ___________________________
Address ______________________________________ Work Phone ___________________________
City/State_____________________ Zip Code __________ Fax Number ___________________________
E-mail_______________________________________

Name ________________________________________ Specialty/Title ________________________
Facility______________________________________ Home Phone ___________________________
Address ______________________________________ Work Phone ___________________________
City/State_____________________ Zip Code __________ Fax Number ___________________________
E-mail_______________________________________

Name ________________________________________ Specialty/Title ________________________
Facility______________________________________ Home Phone ___________________________
Address ______________________________________ Work Phone ___________________________
City/State_____________________ Zip Code __________ Fax Number ___________________________
E-mail_______________________________________

Name ________________________________________ Specialty/Title ________________________
Facility______________________________________ Home Phone ___________________________
Address ______________________________________ Work Phone ___________________________
City/State_____________________ Zip Code __________ Fax Number ___________________________
E-mail_______________________________________

*Please list your current Emergency Department Nurse Manager.*

Name ________________________________________ Specialty/Title ________________________
Facility______________________________________ Home Phone ___________________________
Address ______________________________________ Work Phone ___________________________
City/State_____________________ Zip Code __________ Fax Number ___________________________
E-mail_______________________________________

** If any answer is "yes" to any of the following questions, give full details on a separate attachment*

**APPOINTMENTS / CLINICAL PRIVILEGES / MEMBERSHIPS**

☐ Yes ☐ No 1. Has an assisting physician(s) ever been assigned by a hospital to monitor any aspect of your practice or have you ever been subject to a mandatory concurring opinion requirement?

☐ Yes ☐ No 2. Do you staff, invest in, or own an emergency or minor emergency care facility, laboratory, or other outpatient facility?

**PROFESSIONAL LIABILITY**

☐ Yes ☐ No 3. Have you ever been denied professional liability insurance?

☐ Yes ☐ No 4. Has your current professional liability insurance carrier restricted your coverage or notified you that it intends to reduce or terminate your coverage?

☐ Yes ☐ No 5. Have any professional liability claims/suits ever been filed against you?

If yes, how many? ______ ☐ *If yes, check this box and complete Attachment G on the TDI application.*

☐ Yes ☐ No 6. Have you ever settled any professional liability claim prior to suit being filed with or without admitting liability as a part of the settlement?

☐ Yes ☐ No 7. Are you aware of any inquiry by an attorney representing a patient or family member about medical care you provided, other than those reported to your professional liability carrier?

**HEALTH STATUS**

☐ Yes ☐ No 8. Do you have or have you ever had a physical or mental condition that could affect your ability to exercise the clinical privileges requested?

☐ Yes ☐ No 9. Would an accommodation presently be required in order for you to exercise the privileges requested, safely and competently, or to perform the essential functions of the position?

**CRIMINAL HISTORY**

☐ Yes ☐ No 10. Have there ever been any misdemeanor, felony, or other criminal charges brought against you, including conviction, probation, deferred adjudication, or that were reduced to a lesser charge or subsequently dropped, or that are currently pending (not including minor traffic violations)?

Which practice location(s) is of interest to you?

1) ____________________________________________________________

2) ____________________________________________________________

**COMPLETED APPLICATIONS REQUIRE THE FOLLOWING ITEMS:**
**(Please indicate which items are attached)**

☐ Copy of current Curriculum Vitae

☐ Recent passport size photo"*eqnqt"eqr{+

☐ Copy of current driver's license

☐ Copy of Medical Diploma

☐ Copy of Internship/Residency certificates

☐ Copy of Fellowship certificate

☐ Copy of Board Certification

☐ Copy of all previous and current state license(s)

☐ Copy of current DEA certificate

☐ Copy of malpractice facesheets for previous 5 years

☐ Copy of current PPD, within previous 12 months or chest x-ray narrative if PPD positive

☐ Copy of immunization records or titers: MMR, Tdap, Hep B, Varicella, Annual Flu, Annual Mask Fit (Parkland Memorial Hospital)

☐ Copy of naturalization papers, green card or visa, if applicable

☐ Copy of NPI # confirmation

☐ Copy of current ATLS certificate, if applicable

☐ Copy of current ACLS certificate (Parkland and/or Children's AHA certified only), if applicable

☐ Copy of current PALS certificate (Parkland and/or Children's AHA certified only), if applicable

☐ Copy of ECFMG/USMLE certificate, if applicable

☐ Copy of DD214, if applicable

☐ Nkuv"qt"eqrkgu"qh"EOG"etgfkv"hqt"rtgxkqwu"46"oqpvju

☐ Rtqegfwtg"nqi"hqt"rtgxkqwu"46"oqpvju

☐ Fgvckngf"tgurqpugu"vq"cp{"swguvkqpu"cpuygtgf"õ{guö

Ukipcvwtg"qp"Crrnkecvkqp"Fkuenquwtg"Tgngcug

**APPLICATION DISCLOSURE/RELEASE**

Pursuant to the requirements of the Fair Credit Reporting Act, notice is given that a *consumer report*** may be made in connection with your application.

If you are denied a contract, either wholly or partly, because of information contained in a consumer report, a disclosure will be made to you of the name and address of the consumer reporting agency making such report. You will also receive a copy of the report and a statement of your consumer rights.

By signing below you consent to the procurement of a *consumer report* in connection with your application.

Applicant's (printed) First Name: ____________________________________________

Applicant's Middle Name: ____________________________________________

Applicant's Last Name: ____________________________________________

Applicant's Other Last Names: ____________________________________________

Social Security Number*: ______________________ Date of Birth: ______________
**for consumer report purposes only*

**Current Address**

Address: ____________________________________________ Apt. #: __________

City: ______________________ State: __________ Zip: ______________

List all cities, states and counties lived in for the last SEVEN YEARS.
*(If additional space is needed, make attachment or use other side of this page)*

| City | State | County |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |

**** ***A consumer report may consist of employment records, educational verification, licensure verification, driver history, previous addresses, and other public records relative to criminal charges. A credit report will not be requested unless it is deemed pertinent to the functions of the position for which you are applying.***

Applicant's Signature: ______________________________ Date: ______________________________

# AUTHORIZATION TO RELEASE INFORMATION

I have submitted an application to become contracted with an entity for which Emergency Medicine Consultants serves as Management Service Organization (herein after, "Group"), located at 6451 Brentwood Stair Road, Suite 200, Fort Worth, Texas 76112.

I, any and all, hereby authorize individuals, organizations, previous employers, and schools to provide any information they may have regarding me, whether or not it is in their records. This may include otherwise privileged or confidential information relative to my professional qualifications, credentials, clinical and/or professional competence, character, mental, moral behavior or any matter having bearing on my consideration of a practice opportunity offered by or through "Group".

I agree to release all individuals, organizations, previous employees, and schools from all liability for any damages, which may result from issuing this information.

Further, I extend "Group", its authorized representatives, and any third parties, immunity and release from liability for information gathered from public records and/or interviews as outlined above.

Further, I authorize "Group", its authorized representatives, and any third parties, to release the following information to any hospitals or organizations at which I am applying for medical staff privileges. (e.g., verification letters from training institutions, hospital affiliations, personal references, and insurance companies)

I hereby agree to indemnify and hold harmless "Group", its owners, directors, employees, representatives, and agents, from any liability, damages, action, or cause of action resulting from the gathering or release of information outlined above.

I agree that a photocopy of this authorization is to be accepted with the same authority as the original, and I specifically waive written notice from any present or former employer and/or organization, who may provide information based upon this authorized request.

______________________________________________

Name (please print)

______________________________________________

Date of Birth Last 4 digits of Social Security Number

______________________________________________

Maiden/former name (please print)

______________________________________________

Signature Date