SOUTHLAND
EMERGENCY MEDICINE • HOSPITALIST • CONSULTING SERVICES

Please provide the name and address of someone who will always know your forwarding address.

Name ____________________
Relationship ____________________
Address ____________________
City/State/Zip ____________________
Phone ____________________

Applicant agrees (i) that the information contained herein and the references obtained and verification received in connection with processing this Application may be disclosed to any professional liability insurance company, hospital, or healthcare facility making a written request thereof, (ii) that all of the information contained herein is true and correct and that if anything contained herein is false, Southland Emergency Medical Services, LLC. may immediately terminate any contract entered into with Applicant, and (iii) that Applicant shall notify Southland Emergency Medical Services, LLC. in writing if any of the answers or information contained herein becomes incorrect or incomplete.

Signature of Applicant ____________________ Today's Date ____________________

Authorization and Release

Southland Emergency Medical Services, LLC. and its directors, officers, and representatives (collectively "SEMS") are hereby authorized to consult with the employees and medical staff members of any medical facility with which I have been associated, and with such other individuals or organizations including past and present insurance malpractice carriers, state medical boards of which I have been a member, private practitioners, hospitals with which I have been associated and medical schools that I have attended or others in order to obtain information bearing on my academic record work record, professional performance or other evaluations. I hereby release and discharge SEMS and all such individuals or organizations providing such information and any and all persons, employees, representatives or agents of any of the above from any and all liability or claims of any nature in connection with the information furnished hereunder. I further consent to the release of information obtained to SEMS' client hospitals, clinics, and healthcare providers. I understand that it may be difficult to obtain the background information unless it is solicited in a confidential manner. I understand and agree that I will not have access to this information and I waive any right of access to such information that I may have under the laws of any state or of the United States except as may be required by court order. A copy of this Authorization and Release may be provided to each individual, hospital, or other organization where information on my credentials is sought and shall remain in effect until specifically revoked in writing by me.

Typed or Printed Name of Applicant ____________________

Signature of Applicant ____________________ Date ____________________

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Physicians Assistant Application

Please attach your resume. Please type or print in black ink.

Name ____________________
Home Address ____________________
City ____________________ State ____________________ Zip ____________________
Home Phone ____________________ Work Phone ____________________
Present Position ____________________ Specialty ____________________
Email Address ____________________ Cell ____________________
Date of Birth ____________________ Social Security No. ____________________

Pre-Medical Education

School of Graduation ____________________
City & State ____________________
Major ____________________ Degree ____________________
Dates Attended ____________________ To ____________________

Medical Professional Education (Please list all institutions attended. Use additional sheet if needed.)

School of Graduation ____________________
Street Address ____________________
City ____________________ State ____________________ Zip ____________________
Dates Attended ____________________ To ____________________

Internship (if applicable) Please list all institutions attended. Use additional sheet if needed.

Hospital ____________________
Street Address ____________________
City ____________________ State ____________________ Zip ____________________
Dates Attended ____________________ To ____________________
Program Director ____________________

Practice Experience

Please list professional experience from reverse chronological order. If applicable, please include patient volume and active military duty. Attach a separate sheet if necessary.

Practice Name ____________________ Type ________________
Address ____
____
Dates from __________ *to* __________

****

Practice Name ____________________ Type ________________
Address ____
____
Dates from __________ *to* __________

****

Practice Name ____________________ Type ________________
Address ____
____
Dates from __________ *to* __________

****

Practice Name ____________________ Type ________________
Address ____
____
Dates from __________ *to* __________

Continuing Medical Education

On a separate sheet list postgraduate activities attended or for which you have received credit in the past two years. List scientific papers or essays you have written. Do not include meetings attended as part of residency training.

Military Experience

Branch of Service __________ Date of Entry __________ Date of Discharge __________

Type of Discharge ____

Certification

National Certification ________________ Date ________________

Number ________________ Renewal ________________

Provider: ☐ BLS Exp. ________ ☐ ACLS Exp. ________ ☐ ATLS Exp. ________

☐ PALS Exp. ________ ☐ APLS Exp. ________

Instructor: ☐ BLS Exp. ________ ☐ ACLS Exp. ________ ☐ ATLS Exp. ________

Professional References

List the names, addresses and phone numbers of professional references from training programs and/or current associates. One should be a department director or a physician of comparable authoritative status. References should be directly familiar with your medical abilities. Two of these references should have worked with you in the last three years, preferably in your specialty.

Name ________________ Specialty ________________
Address ________________ Relationship ________________
City/State/Zip ________________ Phone ________________
Did reference have direct contact with you? ______ Date of contact *from* ______ to ______

Name ________________ Specialty ________________
Address ________________ Relationship ________________
City/State/Zip ________________ Phone ________________
Did reference have direct contact with you? ______ Date of contact *from* ______ to ______

Name ________________ Specialty ________________
Address ________________ Relationship ________________
City/State/Zip ________________ Phone ________________
Did reference have direct contact with you? ______ Date of contact *from* ______ to ______

Licensure *(Please list all certificates or licenses ever held, both active and inactive. Use additional sheet if necessary.)*

State	License Number	Date Issued	Exp.	Current, Active Or Pending	DEA #

Additional Information

Please list on a separate sheet all of your professional liability carriers in the past ten years.

Do you have current professional liability insurance? ☐ No ☐ Yes Company
Policy # ________________ Policy Limits ________________

If the answer to any of these questions is "Yes" please give details on separate sheet.

Has your license to practice in any jurisdiction ever been suspended, surrendered, limited or revoked? ☐ *Yes* ☐ *No*

Has your request for any specific privilege ever been denied or granted with limitation? ☐ *Yes* ☐ *No*

Have you ever been denied membership on a hospital staff? ☐ *Yes* ☐ *No*

Have you ever been refused membership or renewal of, or been subject to disciplinary action in any medical membership? ☐ *Yes* ☐ *No*

Have your privileges at any hospital ever been suspended, diminished, revoked or not renewed? ☐ *Yes* ☐ *No*

Have you ever surrendered a Drug Enforcement agency or other controlled substance authorization registration, or has one ever been limited, suspended or revoked? ☐ *Yes* ☐ *No*

Have you ever been denied a professional license? ☐ *Yes* ☐ *No*

Have you ever been subject or aware of any possible professional liability case? ☐ *Yes* ☐ *No*

Have you ever been convicted of a felony or misdemeanor? ☐ *Yes* ☐ *No*

Are you capable to perform the essential functions of the position for which you applied? ☐ *Yes* ☐ *No*