Authorization and Release

Southland Emergency Medical Services, LLC. and its directors, officers, employees, 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 _____

SOUTHLAND

EMERGENCY MEDICINE • HOSPITALIST • CONSULTING SERVICES

Independent Contractor Physician Application

www.southlandmd.com

Please attach your curriculum vitae. Please type or print in black ink.

☐ MD ☐ DO

Attach recent photo (optional)

Name _____
Specialty _____
Home Address _____
City _____
State/Zip _____
Home Phone _____
Work Phone _____ Beeper # _____
Date of Birth (M/D/Y) _____

Place of Birth _____
Citizenship _____
Present Position _____
Social Security # _____
Federal I.D.# (if incorporated) _____ Date of Incorporation _____
Medicare UPIN # _____

Internship (PGY-1) *(Please list all institutions attended. Use separate sheet if needed.)*

Hospital _____
Street Address _____
City _____
State/Zip _____
Dates Attended *from* _____ *to* _____
Type of Internship _____ Program Director _____

Medical Education *(Please list all institutions attended. Use separate sheet if needed.)*

School of Graduation _____
City & State _____
Major _____
Degree _____
Dates Attended *from* _____ *to* _____

Pre-Medical Education

School of Graduation _____
Address _____
City _____
State/Zip _____
Dates Attended *from* _____ *to* _____

Medical Information

Date of Last Physical Exam _____

List significant findings, name of physician and/or institution where performed and dates & causes of all hospitalizations in the past five years. Use separate sheet if needed.

Military Experience

Branch of service _____ Date of Discharge _____ Type of Discharge _____

_____

Practice Preferences

☐ Primary (approximately 2,000 hrs. annually) ☐ Supplemental (limited availability) Preferred start date _____
Geographic Preference(s) 1. _____
2. _____
3. _____

Additional Information

Do you have current professional liability insurance? ☐ No ☐ Yes ☐ Claims Made ☐ Occurrence
Company _____ Policy # _____ Coverage Limits _____

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

	Yes	No	Pending
1. Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily surrendered, limited, suspended or revoked?	☐	☐	☐
2. Have you ever been refused membership on a hospital medical staff?	☐	☐	☐
3. Has your request for any specific clinical privilege ever been denied or granted with stated limitations?	☐	☐	☐
4. Have your privileges at any hospital ever been suspended, diminished, revoked, or not renewed?	☐	☐	☐
5. Have you ever voluntarily or involuntarily surrendered a narcotics registration, or has one ever been limited, suspended, or revoked?	☐	☐	☐
6. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization?	☐	☐	☐
7. Have you ever been subject to or are you aware of any possible Medical Malpractice Claims?	☐	☐	☐
8. Have you ever received treatment for alcoholism, drug abuse, or psychiatric disorders?	☐	☐	☐
9. Have you ever been convicted of or pled guilty to a misdemeanor or a felony?	☐	☐	☐
10. Have you ever been denied a medical license ?	☐	☐	☐
11. Have you ever had any policy for Medical Malpractice Insurance denied, canceled or non-renewed?	☐	☐	☐

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 therefore, (ii) that all of the information contained herein is true and correct and that if anything contained herein is false, Southland Emergency 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 _____

Licensure and Certificates *(Please list all licenses ever held, both active and inactive. Use separate sheet if needed.)*

MEDICAL LICENSURE (State)	LICENSE NUMBER	DATE ISSUED	CURRENT, INACTIVE, OR PENDING	EXPIRATION
1.				
2.				
3.				
4.				
5.				

DEA CERTIFICATE • Registration Number	**STATE**	**EXPIRATION**
1.		
2.		

Certification

USMLE _____ Date _____
FLEX, # _____ Date _____
National Boards Part III, # _____ Date _____
State Boards Examinations _____ Date _____
ECFMG or FMGEMS, # _____ Date _____
Board Certified American Board of Emergency Medicine, Date _____ Recertified Date _____
Board Certified American Board of Osteopathic Emergency Medicine, Date _____ Recertified Date _____
Board Prepared American Board of Emergency Medicine, Date _____
Board Prepared American Osteopathic Board of Emergency Medicine, Date _____
Board Certified American Board of _____ Date _____ Recertified Date _____
Board Certified American Osteopathic Board of _____ Date _____ Recertified Date _____
Board Prepared American Board of _____ Date _____
Board Prepared American Osteopathic Board of _____ Date _____
Provider: ☐ BLS, Exp. Date ☐ ACLS, Exp. Date ☐ ATLS, Exp. Date ☐ PALS ☐ APLS
Instructor: ☐ BLS, Exp. Date ☐ ACLS, Exp. Date ☐ ATLS, Exp. Date ☐ PALS

Professional References

List the names and addresses 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.

1. Name _____ Specialty _____
   Address _____ Relationship _____
   City/State/Zip _____ Phone _____
   Did reference have direct contact with you? ☐ Yes ☐ No, Date of contact *from* _____ *to* _____
2. Name _____ Specialty _____
   Address _____ Relationship _____
   City/State/Zip _____ Phone _____
   Did reference have direct contact with you? ☐ Yes ☐ No, Date of contact *from* _____ *to* _____
3. Name _____ Specialty _____
   Address _____ Relationship _____
   City/State/Zip _____ Phone _____
   Did reference have direct contact with you? Yes ☐ No, Date of contact *from* _____ *to* _____

Practice Experience

List professional experience in reverse chronological order. Please be certain to list all time since medical school not included in postgraduate training. Please include active military duty and Emergency Department volume, if applicable. Attach separate sheet if needed.

Hospital or Practice Name _____ Volume _____
Address _____
_____
Dates *from* _____ *to* _____ Position _____ #hours per month _____

Hospital or Practice Name _____ Volume _____
Address _____
_____
Dates *from* _____ *to* _____ Position _____ #hours per month _____

Hospital or Practice Name _____ Volume _____
Address _____
_____
Dates *from* _____ *to* _____ Position _____ #hours per month _____

Hospital or Practice Name _____ Volume _____
Address _____
_____
Dates *from* _____ *to* _____ Position _____ #hours per month _____

Residency *(Please list all training programs. Use separate sheet if needed.)*

Hospital _____
Street Address _____
City/State/Zip _____
Dates Attended *from* _____ *to* _____
Specialty _____ Program Director _____
Additional Training _____
_____
_____

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.

Professional Societies *(Please list memberships)*

_____
_____
_____

Are You a Member of ACEP? ☐ Yes ☐ No Year joined _____
Are You a Member of ACOEP? ☐ Yes ☐ No Year joined _____