

IPC Physician Employment Application Revised 05/01/2008



Thank you for your interest in employment at IPC - The Hospitalist Company. As the US leader in hospitalist medicine, we are always looking for committed and patient-focused professionals to grow with us. Your application will be considered without regard to age, race, sex, religion, color, national origin, disability, veteran status, marital status, or any other basis prohibited by local, state, or federal law. IPC provides reasonable accommodation to applicants with disabilities who need assistance in participating in the application process. Please make any requests for accommodations to the IPC Human Resources Dept. This application should be returned to Physician Staffing, IPC – The Hospitalist Company. All offers of employment are contingent upon successful completion of the IPC background check and credentialing process.

Date of Application: _____ Anticipated Start Date: _____
 Applying for: Full-Time Part-Time Moonlighting

Please indicate the location for which you are applying:

Arizona <input type="checkbox"/> Phoenix <input type="checkbox"/> Tucson California <input type="checkbox"/> Los Angeles <input type="checkbox"/> SF Bay Area <input type="checkbox"/> Thousand Oaks Colorado <input type="checkbox"/> Denver <input type="checkbox"/> Pueblo	Delaware <input type="checkbox"/> Wilmington Florida <input type="checkbox"/> Jacksonville <input type="checkbox"/> Ocala <input type="checkbox"/> SW Florida <input type="checkbox"/> Tampa Georgia <input type="checkbox"/> Macon	Illinois <input type="checkbox"/> Chicago <input type="checkbox"/> Rockford <input type="checkbox"/> Southern IL Massachusetts <input type="checkbox"/> Berkshires <input type="checkbox"/> Boston <input type="checkbox"/> Pioneer Valley Michigan <input type="checkbox"/> Detroit	Missouri <input type="checkbox"/> St. Louis Nevada <input type="checkbox"/> Las Vegas New Hampshire <input type="checkbox"/> Concord North Carolina <input type="checkbox"/> Charlotte Ohio <input type="checkbox"/> Toledo	Oklahoma <input type="checkbox"/> Oklahoma City Pennsylvania <input type="checkbox"/> Lebanon <input type="checkbox"/> Philadelphia Tennessee <input type="checkbox"/> Bristol <input type="checkbox"/> Johnson City <input type="checkbox"/> Nashville	Texas <input type="checkbox"/> Corpus Christi <input type="checkbox"/> Dallas/Ft. Worth <input type="checkbox"/> Houston <input type="checkbox"/> San Antonio Other <input type="checkbox"/> _____ <input type="checkbox"/> _____
---	--	--	---	--	--

Personal Data

First Name	Middle Name	Last Name	MD/DO
Contact Information - Please indicate where you would like correspondence sent: <input type="checkbox"/> Home <input type="checkbox"/> Work			
Address	City	State	Zip
Phone Number	Pager	Cell Phone	Email Address

Medical Qualification

Have you taken Step 3 USMLE or NBOME? Yes Date Passed: _____ No Date Step 3 scheduled: _____

If you are an international medical graduate: ECFMG Number: _____ Date Issued: _____

Are you board certified? Yes No If Yes, indicate month/year _____

Work Eligibility

Do you have a legal right to remain and work in the United States? Yes No

Will you require sponsorship from IPC in order to obtain work authorization to work for IPC? Yes No

NOTE: Proof of citizenship, permanent residency or employment authorization will be required upon employment.

How did you hear about IPC?

<input type="checkbox"/> Recruiting Agency Name of Recruiter: _____ <input type="checkbox"/> Direct Mail	<input type="checkbox"/> Publication Name of Publication: _____ <input type="checkbox"/> Internet	<input type="checkbox"/> IPC Employee Name of Employee: _____ <input type="checkbox"/> Residency Program Referral	<input type="checkbox"/> Other Please specify: _____ <input type="checkbox"/> Self-Referral
--	---	---	---

Licensure Present and Expired

- List all states where you are currently licensed or have previously been licensed or where you have currently or previously applied for licensure.
 - Please include any additional information on a separate sheet.

1	State	Date Issued	License Number	Expiration Date
2	State	Date Issued	License Number	Expiration Date

IPC Physician Employment Application Revised 05/01/2008

This application should be returned to Physician Staffing, IPC – The Hospitalist Company.



Professional References

- Please list all (4) physicians in your specialty who have observed and evaluated your clinical performance. Please include your program director if training was completed within the past two years.

	1	2	3	4
Physician Name:				
Title or Affiliation:				
Specialty:				
Address:				
City/State/Zip:				
Email Address:				
Phone:				
Fax:				

Practice Experience

- Please start with the most recent practice or employment. International Medical Graduates, please include practice experience from medical school to U.S. Attach separate sheet if necessary.

1	Employer	Date of Attendance:	
		From: (Mo./Yr.)	To: (Mo./Yr.)
	Address:	City	State Zip
	Supervisor	Phone	Fax
Reason for Leaving:			
2	Employer	Date of Attendance:	
		From: (Mo./Yr.)	To: (Mo./Yr.)
	Address:	City	State Zip
	Supervisor	Phone	Fax
Reason for Leaving:			
3	Employer	Date of Attendance:	
		From: (Mo./Yr.)	To: (Mo./Yr.)
	Address:	City	State Zip
	Supervisor	Phone	Fax
Reason for Leaving:			

IPC Physician Employment Application Revised 05/01/2008

This application should be returned to Physician Staffing, IPC – The Hospitalist Company.



Professional Liability Coverage

Have you ever insured with a state funded agency? Yes No

If yes, which states: _____

List ALL insurance carriers (including insurance companies, state-funded agencies, hospitals, clinics, employers, etc.) who have provided Professional Liability Coverage for you since completion of your graduate medical education. Attach separate sheet if necessary.

1	Current Insurance Carrier	Agent
	Address:	City State Zip
	Phone Number Fax	Policy Number Date of Coverage: From: To:
	Circle One: Occurrence / claims made	Coverage Limits
2	Previous Insurance Carrier	Agent
	Address:	City State Zip
	Phone Number Fax	Policy Number Date of Coverage: From: To:
	Circle One: Occurrence / claims made	Coverage Limits

Professional Liability History

- If the answer to any of the following questions is "Yes", please give full details in the next section "Professional Liability Claim Information". Answering yes does not disqualify your application. Each case will be judged on its own merits with respect to its effect on your professional qualification and competence.

A	Have you ever been named as a defendant, and/or alleged to have been negligent, in a professional liability case in the past ten (10) years ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B	Within the past ten (10) years , has the care which you provided been the subject of any claim of negligence or other action for damages?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C	Are you aware of any circumstances which have occurred that may result in malpractice claims or suits being brought against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D	Have you ever had professional liability insurance denied or cancelled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E	Has your professional liability coverage or insurance policy ever been revoked, cancelled or relinquished (whether voluntarily or involuntarily) under a threat of cancellation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F	Have you ever practiced without professional liability coverage when you where required to have it? If so, please state the reason(s) why on a separate sheet.	<input type="checkbox"/> Yes <input type="checkbox"/> No

- If you answered "yes" to any of the Professional Liability questions, please provide a detailed explanation below. **Duplicate this form as necessary to complete a separate sheet for EACH action or allegation.** Use reverse side of this form if additional space is needed.

If you have no Professional Liability claims to report, please sign and return this page.

Signature of Applicant _____
Date

IPC Physician Employment Application Revised 05/01/2008

This application should be returned to Physician Staffing, IPC – The Hospitalist Company.



Malpractice Actions – Professional Liability Claim Form

Applicant Name

Patient Name Diagnosis

Your involvement in the care (Attending, Consulting, etc.) Your status in the case (sole defendant, co-defendant, ownership interest in Provider practice named in suit, etc.)

Allegations made against you

Clinical Case Summary

Patient Outcome

Other Pertinent Details

Date of Incident	Date Filed	Date Case Closed	Settlement Amount Paid on Your Behalf
------------------	------------	------------------	---------------------------------------

Resolution of Case

<input type="checkbox"/> Dismissed	<input type="checkbox"/> Pending	<input type="checkbox"/> Other _____
<input type="checkbox"/> Settlement out of Court	<input type="checkbox"/> Arbitration	_____
<input type="checkbox"/> Litigated	<input type="checkbox"/> Mediation	

Professional Liability Insurer Name (if one was involved) Insurer Address: (Street, City, State, Zip)

Insurer Telephone Number Insurer Policy Number

I hereby declare that the above information is, to the best of my knowledge and belief, complete and accurate.

Signature of Applicant Date

Print Name

IPC Physician Employment Application Revised 05/01/2008

This application should be returned to Physician Staffing, IPC – The Hospitalist Company.



Practice Review

-If you answer "yes" to any of the following Practice Review questions, please provide a detailed explanation on separate sheet of paper.
-Answering "yes" to any Practice Review questions does not disqualify your application. Each case will be evaluated on its own merits with respect to its effect on your professional qualifications and competence.

1	Are you now or have you ever been monitored by a hospital, state, or other Impaired Physician program or similar monitoring or treatment program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2	Have you ever been denied a medical license of any type, whether full, limited, or temporary?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3	Has your medical license, DEA License, or other license entitling you to practice medicine in any jurisdiction been restricted, refused, suspended or revoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4	Have any formal or written complaints been filed against you with any State Medical Board or the National Practitioner Database?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5	Has your specialty or subspecialty board certification ever been denied, suspended, revoked or placed on probation, or is such an action pending now?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6	Have you ever been fined by any state or federal agency relating to any issue involving healthcare?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7	Are you now or have you been on a Corrective Action Plan with any state or federal agency or Peer Review Organization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8	Has any action or investigation ever been taken against you by Medicare or any other government-related healthcare agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9	Have you ever been excluded from or sanctioned by Medicare or Medicaid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10	Did you leave an internship, residency, or fellowship without completing it?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11	Have you ever been denied initial or renewal membership, or been subjected to disciplinary proceedings in any facility or medical organization	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12	Have your privileges or memberships on the medical staff of any institution or medical organization ever been placed on probation, denied, suspended, diminished, revoked, not renewed, or have you ever been subject to a disciplinary action completed or ongoing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13	Is there any action pending or in process that might result in denial, suspension, probation, or revocation of your privileges?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14	Are there any limitations that would prohibit you from performing the essential functions of the position for which you are applying? List any limitation(s) to your clinical practice: _____ _____ _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

IPC Physician Employment Application Revised 05/01/2008

This application should be returned to Physician Staffing, IPC – The Hospitalist Company.



Criminal Record Check

Have you ever been convicted of any crime, including motor vehicle violations other than speeding tickets? (A conviction includes a plea, verdict or finding of guilt, regardless of whether sentence is imposed by the court.)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you presently on probation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you presently on parole?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you presently have a criminal matter that is pending trial?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If the position which you are applying for has access to drugs and medications, have you ever been arrested for an offense involving controlled substances? (Section 432.7 Labor Code and Section 11590 Health and Safety Code)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If the position which you are applying for has regular access to patients, have you ever been arrested for any offense involving sexual perversion? (Section 432.7 Labor Code and Section 290 Penal Code)		<input type="checkbox"/> Yes	<input type="checkbox"/> No

The existence of a criminal record does not automatically eliminate you from employment consideration.

Authorization to Release Information and Statement of Applicant

By signing this application, I hereby agree to cooperate fully with IPC – The Hospitalist Company, its medical staff, and its representatives during its investigation and processing of this application. I further agree to appear for all interviews, submit documents, written and/or oral evidence, or such other information as may be requested of me with regard to my application.

I hereby authorize IPC – The Hospitalist Company, its medical staff and its representatives to consult with, obtain and review oral or written information from such other persons or entities as they may deem appropriate, who may have information or evidence bearing on my competence, background, education, licensure, experience, character and ethical qualifications.

I also consent to and authorize the medical staff and representatives of IPC – The Hospitalist Company to obtain any oral or written information or records from any insurance carrier or vendor, any civil or criminal court, the Department of Motor Vehicles, or any other person or entities as they may deem appropriate, pertaining to any claims, suits or causes of action for professional negligence or medical malpractice. I hereby release, acquit and forever discharge IPC – The Hospitalist Company, its medical staff and its representatives, and any and all other entities, vendors and persons who may furnish or submit written or oral information in connection with the investigations and processing of this application form and against any and all liability, claims, causes of action or demands for or by reason of any matter, cause of action, claims or demands for invasion of privacy, libel, slander and negligence which may arise from submission, furnishing, discussion or use of any information described above, either oral or written.

I understand that the information furnished in this application will be provided to IPC's medical malpractice insurance carrier and will form the basis for the carrier's underwriting decision. I agree to notify IPC – The Hospitalist Company promptly of any material changes to my responses to this application that may influence IPC or the insurance carrier's decision, including, but not limited to, material changes to my responses to practice questions, criminal background information, and / or medical history questions.

I, the undersigned applicant, warrant that the information furnished in this application is true and correct and that no information of an adverse nature has knowingly been omitted or misstated. Any misrepresentation of facts on this application is sufficient cause for summary dismissal from employment. No oral representation to the contrary has been made to me, and I further understand that no employee of IPC – The Hospitalist Company is authorized to make any such representation.

Signature of Applicant

Date

Print Name

**IPC – The Hospitalist Company is an Equal Opportunity Employer
EEO/AA/M/FV/ADA**