

IPC Non-Physician Provider Employment Application

Revised 07/01/2010



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 Region: _____

Personal Data

First Name	Middle Name	Last Name	NP/PA
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

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

Board Certification Information

1	Name of Certifying Board	Specialty
	Month/Year Initially Certified	National Certificate Number
		Month/Year of Expiration
	State where certification test was administered	
2	Name of Certifying Board	Specialty
	Month/Year Initially Certified	Additional Certificate Number
		Month/Year of Expiration
	State where certification test was administered	
Please submit a copy of your National Board Certification		

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

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DEA Licensure

Date Issued	License Number	Expiration Date

Professional References

- Please list all (4) providers, including at least one physician, 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. 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:				

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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:
	Check 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:
	Check 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

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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

Dismissed

Pending

Other _____

Settlement out of Court

Arbitration

Litigated

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

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Practice Review		
<p>-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.</p>		
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 ever 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

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Criminal Record Check

Have you ever been convicted of any crime, including motor vehicle violations other than speeding tickets? Yes No
(A conviction includes a plea, verdict or finding of guilt, regardless of whether sentence is imposed by the court.)

Are you presently on probation? Yes No

Are you presently on parole? Yes No

Do you presently have a criminal matter that is pending trial? Yes 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) Yes 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) Yes No

If you answered yes to any of the criminal record questions, please provide a detailed explanation on a separate sheet of paper.

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.

Where required by law or government contract or for other business reasons, IPC participates in E-Verify. Currently, IPC uses E-Verify for new employees in Arizona, Tennessee and South Carolina. IPC may add all or other of its operations to E-Verify participation in its sole discretion and without further notice. If you have questions about IPC's E-Verify participation, please contact Human Resources at 1 (888) 731-3395.

For any hiring site where IPC participates in E-Verify, IPC will provide the Social Security Administration (SSA) and, if necessary, the Department of Homeland Security (DHS) with information from each new employee's Form I-9 to confirm work authorization. If the Government cannot confirm that you are authorized to work, IPC is required to provide you written instructions and an opportunity to contact SSA and/or DHS before taking adverse action against you, including terminating your employment. Employers may not use E-Verify to prescreen job applicants or to re-verify current employees and may not limit or influence the choice of documents presented for use on the Form I-9. In order to determine whether Form I-9 documentation is valid, IPC uses E-Verify's photo screening tool to match the photograph appearing on some permanent resident and employment authorization cards with the official U.S. Citizenship and Immigration Services' (USCIS) photograph. If you believe that your employer has violated its responsibilities under this program or has discriminated against you during the verification process based upon your national origin or citizenship status, please call the Office of Special Counsel at 1 (800) 255-7688.

Signature of Applicant

Date

Print Name: _____

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