PRE-APPLICATION

ORIGINATOR

(PLEASE TYPE OR PRINT, ANSWER ALL QUESTIONS AND ATTACH CV/RESUME)

DATE OF APPLICATION	AVAILABILITY DATE	LOCATION/REGION	Number of hours/weeks available to work

POSITION APPLIED FOR ☐ MD ☐ DO ☐ PA ☐ NP ☐ FULL TIME ☐ PART TIME / PER DIEM ☐ LOCUM

HOW DID YOU HEAR ABOUT US? ☐ WEBSITE ☐ ADVERTISMENT ☐ REFERRAL ☐ EMPLOYMENT AGENCY ☐ EMPLOYEE ☐ OTHER:

HAVE YOU EVER WORKED FOR THIS COMPANY? ☐ YES ☐ NO IF YES, WHEN AND WHAT LOCATION?

ARE YOU AUTHORIZED TO WORK IN THE UNITED STATES? (Proof of citizenship, permanent residency or immigration status will be required upon employment) ☐ YES ☐ NO

HAVE YOU, SINCE THE AGE OF 18, EVER BEEN CONVICTED OF A FELONY? ☐ YES ☐ NO IF YES, EXPLAIN:

PERSONAL DATA

FIRST NAME	M.I.	LAST NAME	☐ MD ☐ DO ☐ PA ☐ NP

HOME ADDRESS / MAILING ADDRESS (APARTMENT/UNIT NO.)	CITY	STATE	ZIP

HOME PHONE NUMBER	CELLULAR NUMBER	FAX NUMBER	EMAIL ADDRESS

GENDER: ☐ MALE ☐ FEMALE	ALL OTHER NAMES USED BY WHICH YOU HAVE BEEN KNOWN (MAIDEN):	DATE OF BIRTH	SOCIAL SECURITY NUMBER

LICENSE #	EXPIRES	MEDICAL/PROFESSIONAL EDUCATION	YEAR OF GRADUATION
DEA #	EXPIRES	ARE YOU BOARD CERTFIED? IF YES, INDICATE BOARD AND MONTH/YEAR: ☐ YES ☐ NO ☐ ELIGIBLE	MONTH/YEAR CERTIFIED

CSR #	EXPIRES	NPI	ACLS	EXPIRES	ARE YOU REGISTERED WITH THE CAQH? ☐ YES ☐ NO

PROFESSIONAL/PEER REFERENCES (Within same degree type: MD/DO = MD/DO, PA/NP = PA/NP)

NAME:	COMPLETE ADDRESS: (Street, City, State, Zip) E-MAIL ADDRESS:	PHONE NUMBER: FAX NUMBER:
NAME:	COMPLETE ADDRESS: (Street, City, State, Zip) E-MAIL ADDRESS:	PHONE NUMBER: FAX NUMBER:
NAME:	COMPLETE ADDRESS: (Street, City, State, Zip) E-MAIL ADDRESS:	PHONE NUMBER: FAX NUMBER:

My signature certifies that I am authorized to practice my specific specialty in accordance with the Laws of the State(s) in which I am licensed and/or certified; and hereby affirm that the information given in or attached to this application is complete, true and accurate under the penalty of perjury. ⌦

CANDIDATE SIGNATURE DATE

CONTRACT PREPARATION [FOR OFFICE USE ONLY]

☐ NEW HIRE ☐ STATUS CHANGE ☐ FULL TIME ☐ PART TIME/PER DIEM ☐ PERMANENT ☐ VISA TYPE: ________ EFFECTIVE DATE: ___________

SELECT DESIRED DIVISION

☐ BEA	☐ EXIGENCE	☐ EXIGENCE HOSPITALISTS	☐ IMMEDIATE CARE
☐ MHB/MACC ☐ KMH ☐ SOCH ☐ SOCH@SJC ☐ MSM	☐ LOURDES ☐ BRMC ☐ MEMORIAL ☐ SJM ☐ OGH ☐ WCA	☐ MSM ☐ SJM ☐ ECMC / _____________	☐ WNY: TR,NFB,OP,CHK,DEL ☐ TX: AUSTIN, ROUND ROCK ☐ ROCH: GREECE, WEBSTER
SPECIFY PRIMARY SITE:	SPECIFY PRIMARY SITE:	SPECIFY PRIMARY SITE:	SPECIFY PRIMARY SITE:

PAYROLL INFORMATION:

RATE		INCENTIVE		SIGN ON BONUS	SCHEDULED PAYOUT	ANNUAL BONUS	SCHEDULED PAYOUT	MALPRACTICE: ☐ NONE
$___________	☐ HOURLY ☐ ANNUAL	$___________	☐ HOURLY ☐ ANNUAL					☐ EPIC ☐ MLMIC ☐ PRI

STIPEND	ANNUAL CME ALLOWANCE/REIMBURSEMENT	TRAVEL/LODGE	PAYROLL FREQUENCY
$_____________________	$_____________________________________	$__________	BI-WEEKLY MONTHLY

☐ YES ☐ NO LIFE INSURANCE ☐ YES ☐ NO HEALTH INSURANCE ☐ YES ☐ NO LONGTERM DISABILITY ☐ YES ☐ NO VACATION/HOLIDAY: _____________

APPROVAL:

INTERVIEW DATE & TIME: ____________________

SUBMIT CONTRACT TO:
☐ CORP COUNSEL _________ DATE
☐ ACCOUNTING _________ DATE

Approved by

Title

Rev 1/2012

Exigence GROUP

Authorization for Release of Information

I, ____________________________, authorize Exigence North America, LLC or its authorized representatives to verify any information concerning my employment, association or partnership with any third parties. I also authorize Exigence North America, LLC or its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, licensing and certification, malpractice history, character, physical and mental health, or any other matter bearing on my satisfaction of criteria for inclusion as a partner, member, employee or contractor of one or more of the companies affiliated with Exigence North America, LLC, as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties relating to such questions.

I also specifically authorize third parties to release information referred to in the preceding paragraph to Exigence North America, LLC or its authorized representatives upon request and I release from liability and hold harmless all persons who furnish such information.

I hereby waive any right to a judicial proceeding or any other proceeding which might be brought, and release from liability Exigence North America, LLC, and its agents or employees from liability damages or other relief for any acts pertaining to any information or decision involving my application.

I hereby authorize and consent to the release of information by Exigence of North America, LLC, or its authorized representative to hospitals wherein clinical privileges for myself are sought or held. This authorization for release of information shall remain in effect for a period of two (2) years after the date signed below.

____ ___________________________

Signature of Provider/Applicant Date

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Printed Name of Provider/Applicant