tinkbird
healthcare staffing

DOCUMENTS TO SUBMIT WITH APPLICATION:

- Curriculum Vitae
- Board Certification
- Medical School Diploma
- Internship/Residency/Fellowship Certificates
- Completed Provider Application
- Completed Provider Contact Information Form
- Signed TinkBird Healthcare Staffing Provider Locums Tenens Agreement
- Copy of Medical License
- Copy of Medical License Registration
- Copy of current DEA registration
- Copy of ACLS/ATLS/BLS/NALS/PALS/NRP certificates (if applicable)
- Copy of NPI (National Provider Identifier) Number
- Copy of Immunizations
- Copy of Social Security Number for accounting purposes
- Clear copy of Driver's License
- 2 Reference letters and/or reference contact information
- Voided check for direct deposit (optional)

IDENTIFYING INFORMATION

Last Name	First Name	Middle Name	Previous Surname	Suffix

Degree ☐ MD ☐ DO ☐ PA ☐ NP ☐ Other (Please Specify)

Social Security Number	NPI Number	Date of Birth*
Birth City	Birth State/ Province	Birth Country
Primary Practice Specialty	Secondary Practice Specialty	

Are you able to legally work in the United States? ☐ Yes ☐ No
If yes, please indicate the following: ☐ U.S. Citizen ☐ Visa or work authorization (*You may be asked to provide proof of eligibility to work in the U.S.)*

Other than English, please list all languages you speak:

*Used for credentials verification purposes only. TinkBird Healthcare Staffing does not discriminate on the basis of age or other factors.

PREFERRED ADDRESS

Address	Apt/Unit Number	Email

City	State/Province	Zip Code	Country

Home Phone Number	Work Phone Number	Cell Phone Number

PROFESSIONAL LIABILITY

Have you **ever** been involved in a malpractice claim(s) (including dismissed actions)? ☐ Yes (**If yes, how many? _____ Attach Supplemental Claims Form for each.**) ☐ No

Has any monetary payment ever been made by you or on your behalf because of alleged medical malpractice? ☐ Yes ☐ No

Are there currently any pending medical malpractice claims or settlements involving yourself? ☐ Yes ☐ No

Has your professional liability insurance coverage ever been denied, limited or canceled by the action of any insurance company? ☐ Yes ☐ No
If yes, attach explanation on a separate sheet.

Has your current liability insurance carrier excluded any specific procedures from your insurance coverage? ☐ Yes ☐ No
If yes, list excluded procedures with full explanation and dates of limitations on a separate sheet.

ACTIONS, LIMITS, SANCTIONS

If your answer is "yes" to any of these questions, **please provide full details on a separate sheet.**

Have any of the following been, or are any currently in the process of being, investigated, denied, revoked, suspended, refused, limited, placed on probation or placed under other disciplinary action?

(a) Medical license in any state ☐ Yes ☐ No
(b) Other professional registration/license ☐ Yes ☐ No
(c) DEA registration ☐ Yes ☐ No
(d) Academic appointment ☐ Yes ☐ No
(e) Membership and/or employment on any hospital medical staff ☐ Yes ☐ No
(f) Clinical privileges/other rights on any medical staff ☐ Yes ☐ No
(g) Other institutional affiliation or status ☐ Yes ☐ No
(h) Professional society membership or fellowship/board ☐ Yes ☐ No
(i) Professional office ☐ Yes ☐ No
(j) Participation in any private, state, or federal health insurance program (e.g., Medicare, Medicaid) ☐ Yes ☐ No
(k) Any other type of professional sanction ☐ Yes ☐ No

DISCIPLINARY ACTIONS

If your answer is "yes" to any of these questions, **please provide full details on a separate sheet.**

Have you ever been convicted of a misdemeanor or felony, or are you currently under indictment or charged with any alleged criminal activities? If so, please provide details below:

Have you ever been the object of an administrative, civil or criminal complaint or investigation regarding sexual misconduct? ☐ Yes ☐ No

Have you ever been placed on probation or disciplined by any training program? ☐ Yes ☐ No

Have you ever voluntarily surrendered your medical license, staff privileges, DEA registration or consented to a limitation of the same pending a review or investigation? ☐ Yes ☐ No

Are there any other issues that should be disclosed that may have an adverse impact on your ability to deliver effective medical services? ☐ Yes ☐ No

HEALTH STATUS

If your answer is "yes" to any of these questions, **please provide full details on a separate sheet.**

Do you currently have any chemical substance abuse dependency?	☐ Yes ☐ No
Are there any reasons that would prevent you from being able to perform competently the job-related functions of a locum tenens physician?	☐ Yes ☐ No
Are there any reasons that would prevent you from being able to travel and promptly assume locum tenens physician responsibilities in unfamiliar facilities?	☐ Yes ☐ No

PREMEDICAL EDUCATION

College or University	Degree	Honors
City	State/Province	Date of graduation (mm/yyyy)

MEDICAL EDUCATION

Medical School				Phone
Address	City	State/Province	Zip Code	Country
Degree awarded	Attended from (mm/yyyy)	Attended to (mm/yyyy)		Date of graduation (mm/yyyy)
U.S./Canadian Medical School: If Medical School is greater or less than 4 years, please explain.				

FIFTH PATHWAY EDUCATION ☐ Yes ☐ No (If yes, please complete this section.)

Institution				Phone
Address	City	State/Province	Zip Code	Country
Specialty	Program completed ☐ Yes ☐ No (If no, please explain on a separate sheet)	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Date of completion (mm/yyyy)

OTHER GRADUATE SCHOOL ☐ Yes ☐ No (If yes, please complete this section.)

College or University				Phone
Address	City	State/Province	Zip Code	Country
Major	Degree awarded	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Date of completion (mm/yyyy)

INTERNSHIP

Institution				Phone
Address	City	State/Province	Zip Code	Country
Type/Specialty	Program completed ☐ Yes ☐ No (If no, please explain on a separate sheet)	Program Chair	Attended from (mm/yyyy)	Attended to (mm/yyyy)

RESIDENCY(IES) ☐ Yes ☐ No (If yes, please complete this section.)

Institution				Phone
Address	City	State/Province	Zip Code	Country
Type/Specialty	Program completed ☐ Yes ☐ No (If no, please explain on a separate sheet)	Program Chair	Attended from (mm/yyyy)	Attended to (mm/yyyy)
Institution				Phone
Address	City	State/Province	Zip Code	Country
Type/Specialty	Program completed ☐ Yes ☐ No (If no, please explain on a separate sheet)	Program Chair	Attended from (mm/yyyy)	Attended to (mm/yyyy)

FELLOWSHIP OR PRECEPTORSHIP ☐ Yes ☐ No (If yes, please complete this section.)

Institution				Phone
Address	City			Country
Type/Specialty	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Program completed ☐ Yes ☐ No (If no, please explain on a separate sheet)	Program Chair

Electronic Medical Records ☐ Yes ☐ No (If yes, please complete this section.)

Do you have experience with EMR? ☐ Yes ☐ No (If yes, please complete the question below).

What systems have you used?

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BOARD CERTIFICATIONS

Name of specialty board	**Certified?**	**Date** (mm/yyyy)	**Recertified?**	**Date** (mm/yyyy)
	☐ Yes ☐ No		☐ Yes ☐ No	
	☐ Yes ☐ No		☐ Yes ☐ No	

If not board certified, have you been accepted to take a specialty examination? ☐ Yes ☐ No
Date scheduled: _____

If not board certified, how many times have you taken a specialty board examination and failed to pass? _____

Name of Practice/Institution	Was this a locum tenens position? ☐ Yes ☐ No	Phone

Availability

Please select the type of availability you are able to work: ☐ Sporadic Availability ☐ Full Time Availability ☐ Weekend Availability

Please select the days of the week and state the hours that you are available to work:

	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday	☐ Sunday
From:							
To:							

PROFESSIONAL LICENSES & CONTROLLED SUBSTANCES PERMITS

*Please list ALL **current** state medical licenses and state controlled permits*

State	**License Number**	**Date Issued (mm/dd/yyyy)**	**Expiration Date (mm/dd/yyyy)**	**Controlled Substance Permit Number**	**Date Issued (mm/dd/yyyy)**	**Expiration Date (mm/dd/yyyy)**

INACTIVE LICENSES ☐ Yes ☐ No (If yes, please complete this section.)

List all States with inactive licenses

DEA REGISTRATION ☐ Yes ☐ No (If yes, please complete this section.)

Registration Number	Date issued (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)
Registration Number	Date issued (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)
Registration Number	Date issued (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)

If you do not currently possess a DEA Registration, please explain here:

ECFMG/FMGEMS ☐ Yes ☐ No (If yes, please complete this section.)

Certificate Number	Date issued

MILITARY SERVICE ☐ Yes ☐ No (If yes, please complete this section.)

Branch	Start Date (mm/yyyy)	End Date (mm/yyyy)

Status: ☐ Active ☐ Honorable Discharge ☐ Dishonorable Discharge ☐ Other (please specify)

PROFESSIONAL REFERENCES

*Please list at least three professional references within your specialty with whom you have had **CLINICAL** contact in the past two years. They must be able to assess your professional skills and capabilities. Verbal references will be kept confidential. When possible, please let the reference know TinkBird Healthcare Staffing will be calling. If you are just completing a residency or fellowship, please list your Program Chair as one of the references. **If you are unable to provide two same specialty references, an explanation is required.***

Name	Position/Relationship	Work Phone ( )	Fax ( )
Address	Primary Practice Specialty	Email	Home Phone ( )

City	State/Province	Zip Code	Worked with from (mm/yyyy)	Worked with to (mm/yyyy)

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Name	Position/Relationship	Work Phone ( )	Fax ( )	
Address	Primary Practice Specialty	Email	Home Phone ( )	
City	State/Province	Zip Code	Worked with from (mm/yyyy)	Worked with to (mm/yyyy)
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Name	Position/Relationship	Work Phone ( )	Fax ( )	
Address	Primary Practice Specialty	Email	Home Phone ( )	
City	State/Province	Zip Code	Worked with from (mm/yyyy)	Worked with to (mm/yyyy)

PROVIDER APPLICATION

I am fully aware that any false information provided may lead to my automatic dismissal. I therefore certify that the information herein is true and complete to the best of my knowledge.

______________________________________ ____________________
Signature of Applicant Date

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