# PHYSICIAN APPLICATION

**All fields are required. Please put "n/a" in any blank fields as appropriate.**

**A NPDB self-query check is required for all interviewing physicians. Please run this self-query and have the results sent to Sara Beth Green at Magnolia Regional Health Center by email sgreen@mrhc.org or mail to MRHC, 611 Alcorn Drive, Corinth, MS 38834. This can be completed by visiting** www.npdb-hipdb.hrsa.gov.

First Name: ____________________________________________________________________

Middle Name: ___________________________________________________________________

Last Name: _____________________________________________________________________

Other names known by that may be referenced in training documents: ________________________

Country(s) of Citizenship: ________________________________________________________

Current Visa Status: _____________________________________________________________

Position(s) of interest within Magnolia Regional Health Center: ____________________________

Name of Hospital Facility: ________________________________________________________

Current Professional/Practice: _____________________________________________________
Name: _________________________________________________________________________
State Location: __________________________________________________________________
Position title: ___________________________________________________________________
Dates employed or in practice: _____________________________________________________

Please verify name, state location, position title and dates employed or in practice for the past 5 years.
*May attach CV with information.*

Current state medical license: _____________________________________________________
License number: _________________________________________________________________

Please list all previous state medical licenses and numbers, current or expired: (mark "C" by all current licenses) ______________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Are you currently board certified? __________________________________________________

Board Certification name and specialty(s): ____________________________________________

If not board certified: _____________________________________________________________

Have you taken the Board Exam? ____________________________________________________

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Have you failed the Board Exam? ____________________________________________________

Have you been accepted to take the Board Exam? ________________________________________

What dates are you scheduled to take the next board exam? _________________________________

**PROFESSIONAL REFERENCES**

List at least three references who can verify your practice experience and locations and who have knowledge of your skills, abilities, judgment, professional performance and clinical competence.

Name: ______________________________________________________________________
Relationship:_________________________________________________________________
Address: ____________________________________________________________________
City: _______________________________________________________________________
State: ______________________________________________________________________
Zip: ________________________________________________________________________
Phone: ______________________________________________________________________
E-mail: _____________________________________________________________________
FAX: _______________________________________________________________________

Name: ______________________________________________________________________
Relationship:_________________________________________________________________
Address: ____________________________________________________________________
City: _______________________________________________________________________
State: ______________________________________________________________________
Zip: ________________________________________________________________________
Phone: ______________________________________________________________________
E-mail: _____________________________________________________________________
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Name: ______________________________________________________________________
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COMMENTS: ____________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**DISCLOSURE QUESTIONS:**

If the answer to any question below is YES, please provide an explanation after the question.

Has your professional license or registration ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished, or not renewed by any licensing board of any health-related agency or organization, or is there a review pending? ________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Has your DEA registration ever been revoked, suspended, limited or conditioned in any way, or have you ever voluntarily relinquished your DEA registration, or is there a review pending? ___________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Has your membership, participation, clinical privileges, or employment ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending? ____________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Have you ever voluntarily or involuntarily relinquished your membership, participation, clinical privileges or request for privileges, employment, professional license, or registration as an alternative to disciplinary action, or prior to or during an investigation into your professional conduct or competence? ___________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

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Have you ever been reprimanded, censured, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization? ___________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Has your certificate or participation in any private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway? __________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Are there any charges pending or are you currently charged with or have you ever been indicted or found guilty of a felony, misdemeanor (other than a minor traffic violation), or other offense involving fraud, misrepresentation or dishonesty? ____________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Have you ever been found liable, guilty or responsible for sexual impropriety or misconduct or sexual harassment? ____________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Have you ever had any professional liability claims or lawsuits brought against you, including pending claims or lawsuits, settlements or final judgments? _____________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Has your professional liability carrier ever refused or canceled your coverage? _____________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

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Have you ever been allowed to resign your employment, medical staff appointment, and/or clinical privileges, rather than face any charge or investigation? ______________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Do you have a condition that would affect your ability, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice without posing a significant health or safety risk to your patients? _________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

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**Attestation:**

By signing below, I certify that the above information and the information provided on my CV is complete and truthful as of this date.
Unless otherwise indicated in the comments section above Magnolia Regional Health Center will contact references listed.

I authorize Magnolia Regional Health Center to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, ethics, behavior or any matter reasonably having a bearing on my qualifications and authorize such third parties to release information to MRHC and authorized representatives.

Signature:____________________________________

Date:______________________

Name:_______________________________________
(please print or type)

______________________
Date