



## 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. This can be completed by visiting [www.npdb.hrsa.gov](http://www.npdb.hrsa.gov). Please run this self-query and have the results sent to Anna McCalla, Physician Recruiter, at Magnolia Regional Health Center by emailing [amccalla@mrhc.org](mailto:amccalla@mrhc.org) or mail to MRHC, 611 Alcorn Drive, Corinth, MS 38834.

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? \_\_\_\_\_  
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 location 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: \_\_\_\_\_  
Fax: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_  
Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Fax: \_\_\_\_\_



Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DISCLOSURE QUESTIONS:**

If the answer to any questions 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?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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?

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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?

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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? \_\_\_\_\_

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

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

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

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