



# Allied Health Provider Reapplication





Dear Provider:

Welcome to locum tenens with Medical Doctor Associates, LLC the quality leader in medical staffing. Please complete and return the enclosed application packet along with copies of the documents listed below.

- Current Curriculum Vitae** ~ *(the CV must include your work history, from completion of training to the present. All dates must include month & year, and not contain any gaps in time)*
- All Training Program Diplomas (if Advanced Practice, please provide both RN and Advanced Practice Information)** *(as applicable)*
- Certification – as applicable** *(Certificate or Letter)*
- All Active and Inactive State Licenses (if Advanced Practice, please provide both RN and Advanced Practice Information)** *(Wallet Copy)*
- DEA/CDS Certificates** *(as applicable)*
- IRS W-9 Form**
- Advanced Cardiac Life Support (ACLS); Basic Cardiac Life Support (BCLS); Advanced Trauma Life Support (ATLS); Pediatric Advanced Life Support (PALS)** *(please include copies of all applicable)*
- Current Certificate of Insurance** *(if not utilizing MDA's coverage)*
- National Practitioner Identifier (NPI) Number Confirmation Letter/Email**
- Current Photo**
- Current PPD Test Results**
- Current Immunization Listing**

In order to ensure that your application is processed as quickly as possible, please note the following:

- The application must be completed, signed and dated. Please do not leave any areas or questions blank. If the question does not apply, please indicate by marking "N/A".
- Please ensure that legible copies of the items listed above are included with your application packet. These items are important elements of our verification process. If you are not able to provide a requested document, please provide a comment or explanation as to why, and if/when you will be able to obtain and forward.

Once submitted, our Risk Management Department will process your application as quickly as possible. Should you have any questions about your application, or about locums assignments with MDA, please don't hesitate to contact your Staffing Consultant.

Thank you for allowing us the opportunity to work with you!

# INDEPENDENT CONTRACTOR REAPPLICATION - ALLIED HEALTH PROVIDER

## GENERAL INFORMATION

LAST NAME		FIRST NAME			MIDDLE NAME	
DEGREE	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH / /	SSN - -	DRIVER'S LICENSE STATE / NUMBER STATE #		
SPECIALTY			OTHER NAMES USED			MAIDEN
HOME ADDRESS		ADDRESS LINE 2		CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	PAGER		E-MAIL		
MAILING ADDRESS, IF DIFFERENT FROM ABOVE		ADDRESS LINE 2		CITY	STATE	ZIP CODE
OFFICE ADDRESS		ADDRESS LINE 2		CITY	STATE	ZIP CODE
OFFICE PHONE		OFFICE FAX		U.S. CITIZEN? <input type="checkbox"/> YES <input type="checkbox"/> NO If not US Citizen, are you authorized to work in the US? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF NOT US CITIZEN, PLEASE PROVIDE VISA STATUS		BIRTH PLACE (CITY, ST, COUNTRY)		LANGUAGES SPOKEN FLUENTLY		
EMERGENCY CONTACT			RELATIONSHIP	PHONE	CELL PHONE	
DO YOU WISH TO CONTRACT WITH MEDICAL DOCTOR ASSOCIATES AS A CORPORATE ENTITY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME OF ENTITY?						FEDERAL TAX ID #

## CERTIFICATIONS

PLEASE CHECK ALL CERTIFICATIONS THAT MAY APPLY:

<input type="checkbox"/> ACLS	EXPIRATION DATE / /	<input type="checkbox"/> BLS	EXPIRATION DATE / /	<input type="checkbox"/> ATLS	EXPIRATION DATE / /	<input type="checkbox"/> PALS	EXPIRATION DATE / /
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## BOARD CERTIFICATION

SPECIALTY	CERTIFYING BOARD	DATE CERTIFIED / /	RECERTIFICATION DATE / /	CERTIFICATION #
EXPIRATION DATE / /	ELIGIBLE / EXAM DATE <input type="checkbox"/> / /	NOT ELIGIBLE / EXPLANATION <input type="checkbox"/> /		# OF ATTEMPTS

## LICENSES AND IDENTIFICATION NUMBERS

STATE	LICENSE #	STATUS: (ACTIVE OR INACTIVE)	CONTROLLED SUBSTANCE #, IF APPLICABLE	STATE	LICENSE #	STATUS: (ACTIVE OR INACTIVE)	CONTROLLED SUBSTANCE #, IF APPLICABLE

DEA #	EXP DATE / /	NATIONAL PROVIDER ID (NPI)
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## MILITARY SERVICE

BRANCH OF SERVICE	RANK AT DISCHARGE	DATES OF SERVICE: FROM / / TO / /
TYPE OF DISCHARGE:		SERVICE #:

## AVAILABILITY

AVAILABLE WEEKS PER YEAR:	HOW MUCH ADVANCE NOTICE DO YOU REQUIRE?
SPECIFIC PERIODS OF AVAILABILITY OR UNAVAILABILITY:	
AREAS OF GEOGRAPHIC PREFERENCE:	

## PROFESSIONAL REFERENCES

PLEASE LIST FOUR (4) COLLEAGUES WHO HAVE WORKED WITH YOU IN THE PAST TWO (2) YEARS AND CAN ATTEST TO YOUR CLINICAL COMPETENCE. IF POSSIBLE, THESE REFERENCES SHOULD BE WITHIN YOUR SPECIALTY.

NAME	SPECIALTY	INSTITUTION		
PHONE	FAX	E-MAIL		
ADDRESS		CITY	STATE	ZIP CODE
NAME	SPECIALTY	INSTITUTION		
PHONE	FAX	E-MAIL		
ADDRESS		CITY	STATE	ZIP CODE
NAME	SPECIALTY	INSTITUTION		
PHONE	FAX	E-MAIL		
ADDRESS		CITY	STATE	ZIP CODE
NAME	SPECIALTY	INSTITUTION		
PHONE	FAX	E-MAIL		
ADDRESS		CITY	STATE	ZIP CODE

## HOSPITAL AFFILIATIONS (PRIVILEGES) FROM THE LAST MDA APPLICATION TO PRESENT (EXCLUDING LOCUM TENENS AFFILIATIONS)

HOSPITAL / FACILITY	STAFF STATUS	FROM	TO	TO PRESENT
		/ /	/ /	<input type="checkbox"/>
ADDRESS	CITY	STATE	ZIP CODE	
HOSPITAL / FACILITY	STAFF STATUS	FROM	TO	TO PRESENT
		/ /	/ /	<input type="checkbox"/>
ADDRESS	CITY	STATE	ZIP CODE	
HOSPITAL / FACILITY	STAFF STATUS	FROM	TO	TO PRESENT
		/ /	/ /	<input type="checkbox"/>
ADDRESS	CITY	STATE	ZIP CODE	
HOSPITAL / FACILITY	STAFF STATUS	FROM	TO	TO PRESENT
		/ /	/ /	<input type="checkbox"/>
ADDRESS	CITY	STATE	ZIP CODE	

## WORK / PRACTICE HISTORY FROM THE LAST MDA APPLICATION TO PRESENT (EXCLUDING MDA LOCUM TENENS ASSIGNMENTS)

EMPLOYMENT/PRACTICE NAME	POSITION	FROM	TO	TO PRESENT
		/ /	/ /	<input type="checkbox"/>
ADDRESS	CITY	STATE	ZIP CODE	
EMPLOYMENT/PRACTICE NAME	POSITION	FROM	TO	TO PRESENT
		/ /	/ /	<input type="checkbox"/>
ADDRESS	CITY	STATE	ZIP CODE	
EMPLOYMENT/PRACTICE NAME	POSITION	FROM	TO	TO PRESENT
		/ /	/ /	<input type="checkbox"/>
ADDRESS	CITY	STATE	ZIP CODE	

## HEALTH STATUS QUESTIONS

THE FOLLOWING QUESTIONS RELATE TO YOUR HEALTH STATUS AND AFFIRMATIVE ANSWERS ARE NOT A BASIS FOR AUTOMATIC DISQUALIFICATION. THEIR PURPOSE IS TO ASSIST US IN EVALUATING APPROPRIATE PLACEMENTS, TO FACILITATE HIGH QUALITY MEDICAL CARE, AND TO ASSURE THAT ANY NECESSARY PRECAUTIONS ARE IN PLACE. (PLEASE ATTACH ADDITIONAL SHEETS, IF NECESSARY)

<b>1</b>	DO YOU HAVE ANY ALCOHOL OR SUBSTANCE ABUSE PROBLEMS? *IF YES, PLEASE EXPLAIN:	<input type="checkbox"/> YES*	<input type="checkbox"/> NO
<b>2</b>	ARE YOU ABLE TO PERFORM, WITH OR WITHOUT ACCOMMODATION, ALL THE ESSENTIAL FUNCTIONS OF THE LOCUM TENENS ASSIGNMENT/AGREEMENT? **IF NO, PLEASE EXPLAIN:	<input type="checkbox"/> YES	<input type="checkbox"/> NO**
<b>3</b>	HAVE YOU EVER TESTED POSITIVE FOR TUBERCULOSIS OR HAD A POSITIVE TB SKIN TEST? ***IF YES, YOU MAY BE REQUIRED TO PROVIDE A REPORT OF A CURRENT NEGATIVE CHEST X-RAY PERFORMED AFTER PPD AND LESS THAN ONE YEAR OLD	<input type="checkbox"/> YES***	<input type="checkbox"/> NO
<b>4</b>	HAVE YOU BEEN VACCINATED FOR HEPATITIS B?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

## MISCELLANEOUS QUESTIONNAIRE

**\*\*\*\*\*SINCE YOUR LAST APPLICATION TO MDA\*\*\*\*\*** PLEASE EXPLAIN ANY "YES" ANSWERS ON A SEPARATE SHEET.

<b>1</b>	HAS YOUR LICENSE TO PRACTICE IN ANY JURISDICTION BEEN LIMITED, SUSPENDED, REVOKED, VOLUNTARILY SURRENDERED, REPRIMANDED, ADMONISHED, INVESTIGATED FOR A COMPLAINT OR PLACED UNDER INVESTIGATION, CORRECTIVE ACTION, CONSENT ORDER OR PROBATION, HAD LIMITS ON LICENSURE ISSUANCE, BEEN SUBJECT TO LETTERS OF CONCERN, NOTIFICATION OF PROPOSED ACTIONS OR ANY OTHER LICENSING BOARD ACTIVITY NOT RELATED TO ISSUANCE OR RENEWAL?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>2</b>	HAVE YOU BEEN DENIED A LICENSE BY ANY LICENSING BOARD, OR HAVE YOU WITHDRAWN AN APPLICATION FOR LICENSE FOR ANY REASON?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>3</b>	HAVE YOU BEEN DENIED CERTIFICATION BY A SPECIALTY BOARD OR NOT BEEN ALLOWED TO SIT FOR AN EXAM FOR ANY REASON?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>4</b>	HAS YOUR NARCOTICS LICENSE BEEN SUSPENDED, REVOKED, LIMITED OR VOLUNTARILY SURRENDERED, PUT ON PROBATION, OR HAS PROBATION BEEN REVOKED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>5</b>	HAVE YOU BEEN DENIED MEMBERSHIP OR RENEWAL THEREOF, OR BEEN SUBJECT TO DISCIPLINARY ACTION, BY ANY MEDICAL ORGANIZATION OR ENTITY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>6</b>	ARE YOU NOW, OR HAVE YOU BEEN, UNDER SANCTION OR INVESTIGATION WITH REGARD TO MEDICARE AND / OR MEDICAID?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>7</b>	HAVE YOUR PRIVILEGES AT ANY HOSPITAL BEEN DENIED, SUSPENDED, DIMINISHED, REVOKED, WITHDRAWN, OR PLACED UNDER ANY OTHER DISCIPLINARY ACTIONS OR PEER REVIEW, HAVE YOU BEEN NOTIFIED OF ANY PROPOSED ACTIONS, RESTRICTIONS OR SUSPENSION OR HAVE THEY NOT BEEN RENEWED FOR ANY REASON OTHER THAN YOUR OWN VOLUNTARY DECISION NOT TO PRACTICE THERE ANY LONGER?	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>8</b>	HAVE YOU BEEN CONVICTED OF A FELONY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>9</b>	HAVE JUDGMENTS, SETTLEMENTS, OR CLAIMS BEEN MADE AGAINST YOU IN ANY PROFESSIONAL LIABILITY CASE, OR ARE THERE ANY PENDING AGAINST YOU OR ANY GROUP OR OTHER PROFESSIONAL ENTITY OF WHICH YOU ARE A MEMBER?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>10</b>	HAVE YOU BEEN DENIED PROFESSIONAL LIABILITY COVERAGE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>11</b>	HAS THERE BEEN ANY CHANGE IN YOUR PRACTICE / SPECIALTY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>12</b>	HAVE YOU EVER BEEN ASKED TO LEAVE A LOCUM TENENS/PER DIEM/TRAVEL/TEMPORARY WORK ASSIGNMENT PRIOR TO YOUR CONTRACTED WORK END DATE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

## ELECTRONIC HEALTH RECORDS (EHR) / ELECTRONIC MEDICAL RECORDS (EMR)

DO YOU HAVE EXPERIENCE WITH EHR/EMR?  YES  NO

## PROFESSIONAL LIABILITY HISTORY

PLEASE LIST ALL PROFESSIONAL LIABILITY COVERAGE POLICIES IN EFFECT, CURRENT OR PREVIOUS SINCE YOUR LAST APPLICATION. **CHECK ONE.**

YES (coverage since last application, please complete below)       N/A – MDA Coverage Only       NA – No Coverage

<b>1</b>	PRESENT OR PREVIOUS INSURANCE CARRIER					
ADDRESS			CITY	STATE	ZIP CODE	
POLICY #	TYPE OF POLICY <input type="checkbox"/> OCCURRENCE <input type="checkbox"/> CLAIMS MADE	POLICY LIMITS \$    / \$	RETRO. DATE /   /	START DATE /   /	EXPIRATION DATE /   /	
<b>2</b>	PRESENT OR PREVIOUS INSURANCE CARRIER:					
ADDRESS			CITY	STATE	ZIP CODE	
POLICY #	TYPE OF POLICY <input type="checkbox"/> OCCURRENCE <input type="checkbox"/> CLAIMS MADE	POLICY LIMITS \$    / \$	RETRO. DATE /   /	START DATE /   /	EXPIRATION DATE /   /	

RELEASE & AUTHORIZATION

By signing below, I certify that all information submitted in this application is true and complete. All information is considered material and important. Should Medical Doctor Associates agree to be bound under the terms of this application to provide liability coverage, it is understood this policy is void if it is found that there was any attempt to mislead, defraud or lie about any information contained in this application.

I understand that Medical Doctor Associates may introduce me to various facilities in order to provide medical services through Medical Doctor Associates. I agree to work in such referred facilities only through Medical Doctor Associates for the period described in Medical Doctor Associates' contract except upon payment of a reasonable recruitment fee and as otherwise provided in Medical Doctor Associates contract.

I authorize and release to Medical Doctor Associates and its agents, including CREDENTIAL Verification & Licensing Services, any and all specific Military Service records from any and all branches of the Military and its cognate organizations (including but not limited to: Manpower Offices, Personnel Support Detachments and National Personnel Records Centers and their representatives) and all such data, documents and information whether or not it is otherwise privileged or confidential relating to my education, training, performance, personal character, ethics, rank, privilege, and current status.

I authorize Medical Doctor Associates and its agents to consult with any persons, entities, institutions and/or medical licensing boards, including, but not limited to, the Federation of State Medical Boards, who can provide information or documents, privileged or confidential, relating to my professional competence, ethics, personal character and professional liability history; to provide information, both written and oral, regarding the status of any license which I have possessed; to obtain licensure or hospital privileges for me and to obtain any information described above during that process. I release from liability any and all individuals or entities providing such information, in good faith and without malice, and specifically consent to the release of such information. I also release Medical Doctor Associates from any liability arising out of any request for information, in accordance with this application, that it makes, or use or disclosure of information it receives, from third parties regarding my professional competence, ethics, character, and professional liability history.

A photocopy of this document shall be acceptable proof to anyone receiving it of my full authorization.

NAME (printed)

SIGNATURE

DATE



**145 Technology Parkway NW  
Norcross, GA 30092  
1-800-780-3500  
Fax: 770-246-0882**



## Request for Taxpayer Identification Number and Certification

**Give Form to the  
requester. Do not  
send to the IRS.**

<b>Print or type See Specific Instructions on page 2.</b>	Name (as shown on your income tax return)	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate  <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ ..... <input type="checkbox"/> Exempt payee  <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number								

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Employer identification number								

### Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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### General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

#### Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

PASSENGER INFORMATION			
PLEASE ENTER ALL IDENTIFYING INFORMATION AS IT APPEARS ON YOUR DRIVERS LICENSE AND/OR PASSPORT.			
LAST NAME		FIRST NAME	MIDDLE NAME
GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF BIRTH / /	
HOME ADDRESS		CITY	STATE
WORK PHONE		HOME PHONE	CELL PHONE
COPY ITINERARY TO		HOME AIRPORT	
AIR TRAVEL PREFERENCES			
SEATING PREFERENCE (CHECK ONE)	OTHER SEATING PREFERENCES	MEAL REQUEST	
<input type="checkbox"/> Aisle <input type="checkbox"/> Window			
SPECIAL REQUIREMENTS			
FREQUENT FLYER			
PROGRAM		NUMBER	
HOTEL STAY PREFERENCES			
ROOM TYPE	OTHER ROOM PREFERENCES		
EMERGENCY CONTACT INFORMATION			
EMERGENCY CONTACT	PHONE	CELL PHONE	
/			

PLEASE FORWARD TO THE TRAVEL DEPARTMENT.