Standard Physician Application Form

PLEASE PRINT OR TYPE

GENERAL INFORMATION

NAME (LAST, FIRST, MIDDLE)	
DATE OF BIRTH	
MAILING ADDRESS	
REQUESTED SPECIALTY	LIST LANGUAGES OTHER THAN ENGLISH SPOKEN BY PHYSICIAN

PRIMARY LOCATION (PLEASE ATTACH ADDITIONAL SHEET FOR OTHER LOCATIONS)

GROUP PRACTICE NAME (IF APPLICABLE)
MAILING ADDRESS
COUNTY
TELEPHONE

LICENSE

STATE	LICENSE NUMBER	EXPIRATION DATE
DO YOU HAVE A LICENSE IN ANY OTHER STATES OR COUNTRIES? IF YES, PLEASE LIST.		
STATE/COUNTRY	LICENSE NUMBER	EXPIRATION DATE
STATE/COUNTRY	LICENSE NUMBER	EXPIRATION DATE

EDUCATION AND TRAINING

COLLEGE

INSTITUTION NAME	
MAILING ADDRESS	
DEGREE	GRADUATION DATE

MEDICAL SCHOOL

INSTITUTION NAME	
MAILING ADDRESS	
DATES ATTENDED (MONTH/YEAR)	
SPECIALTY	

INTERNSHIP

INSTITUTION NAME	
MAILING ADDRESS	
DATES ATTENDED	

RESIDENCY

INSTITUTION NAME
MAILING ADDRESS
DATES ATTENDED (MONTH/YEAR)
SPECIALTY

AFFIRMATION AND RELEASE

I hearby authorize and consent to the release of information by any hospital or hospital's medical staff, medical associations, National Practitioner Data Bank, other government agencies, malpractice insurance carriers, and previous and present and other interested parties regarding information concerning me. I hereby release the plan, its staff, as well as the institution(s) or organizations providing such information and their staff, from any and all liability for the obtaining and release of such information. I also understand that I have a continuing obligation to amend and update my answers.

By my signature, I hereby attest that the information in this application is complete and accurate and I agree to provide information as required to support this application. The undersigned hereby certifies that the above information requested is truthful, correct and complete in all respects. The undersigned further understands that the submission of false and/or significantly misleading information or the withholding of relevant information is grounds for termination of the contact.

APPLICANT SIGNATURE	DATE