RESET

WATSON CLINIC LLP

Professional Services

Physician Application for Employment

PRACTICE SPECIALTY
SUBSPECIALTY
REFERRED BY

Please be sure to attach all other requested documents in the return email when submitting to wcphysicians@watsonclinic.com.

Please attach a CV that is complete and current as of this date, including your education, and the names, addresses of all employers, including the dates of employment for each. ***CV must be in month/year format.***

Also, attach the face sheet from your malpractice insurance carrier and a headshot photo.

PERSONAL INFORMATION:

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____ SUFFIX _____

OTHER NAMES USED _____ DATE FROM _____ DATE TO _____

PRESENT STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

PERMANENT STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

CELL PHONE NUMBER _____ SECONDARY PHONE NUMBER _____ FAX NUMBER _____

EMAIL ADDRESS _____

Please enter information where you can be best reached if different from above.

PHONE _____ PAGER _____ ANSWERING SERVICE _____

Are you able to perform the essential functions of your medical specialty without any accommodation? ☐ Yes ☐ No

If no, please indicate what accommodations may be necessary: _____

_____

Do you presently have lawful, un-expired authorization to be employed in the United States? ☐ Yes ☐ No

If no, what is your visa status? _____

PROFESSIONAL REFERENCES:

If applying directly from a training program or within 12-24 months of completion:
Program Director required, and Two physicians in the same specialty.

If training was completed more than 24 months prior, and you have been practicing professionally:
Current Department Chair/Med Director/CMO, and two physicians in the same specialty.
**These must be individuals have worked with applicant within 2-3 years.*

Peer Reference Name: _____

Title: _____ Company: _____

Phone #: _____ Email: _____

PROFESSIONAL REFERENCES: *(Continued)*

Peer Reference Name: _____

Title: _____ Company: _____

Phone #: _____ Email: _____

Peer Reference Name: _____

Title: _____ Company: _____

Phone #: _____ Email: _____

SPECIALTIES AND BOARD INFORMATION:

☐ American Board of Medical Specialties (ABMS)
☐ American Board of Physician Specialties (ABPS),
☐ American Osteopathic Association Bureau of Specialists (AOABS)

SPECIALTY	CERTIFYING AGENCY	CANDIDATE #
SPECIALTY	CERTIFYING AGENCY	CANDIDATE #
SPECIALTY	CERTIFYING AGENCY	CANDIDATE #

If not Board Certified, date you will sit for the board examination: _____

Have you ever taken a specialty board examination and failed to pass? ☐ Yes ☐ No

If yes, please provide specialty and date(s) of exam(s) not passed: _____

If yes, please provide board eligibility time frame: _____

Have you ever taken a national board examination (USMLE, FLEX, ECFMG, etc.)? ☐ Yes ☐ No

PROFESSIONAL LICENSES:

List all states where you hold/have held a license.

STATE	LICENSE NUMBER	STATUS	EXPIRATION DATE
STATE	LICENSE NUMBER	STATUS	EXPIRATION DATE
STATE	LICENSE NUMBER	STATUS	EXPIRATION DATE
DEA LICENSE NUMBER	STATE OF CERTIFICATE	STATUS	EXPIRATION DATE
ECFMG LICENSE NUMBER	STATUS	EXPIRATION DATE	

Have you ever been investigated, charged or disciplined by any professional licensing authority? ☐ Yes ☐ No

If yes, please explain:

EDUCATION & EMPLOYMENT:

Have you ever been investigated, charged, disciplined, or placed on probation by a medical school, hospital, or health care entity during your training? ☐ Yes ☐ No

If yes, please explain:

Please list your 2 most recent employers:

Employer Name: _____ Date Employed:(MM/YY) FROM _____ TO _____

City _____ State _____ Phone Number: _____

EDUCATION & EMPLOYMENT: *(Continued)*

Employer Name: _____ Date Employed:(MM/YY) FROM _____ TO _____

City _____ State _____ Phone Number: _____

PROFESSIONAL LIABILITY:

1. Do you currently have malpractice insurance? ☐ Yes ☐ No
2. If no, do you have an escrow account of cash or assets eligible for deposit in accordance with FL s.625.52 or an irrevocable letter of credit from an authorized insurer of not less than $300,000? ☐ Yes ☐ No

PLEASE PROVIDE A COMPLETE, SIGNED AND DATED EXPLANATION, INCLUDING NAMES AND DATES, IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED IN THE AFFIRMATIVE.

3. Has your professional liability insurance coverage ever been suspended, denied, canceled, or voluntarily relinquished? ☐ Yes ☐ No
4. Have you ever been denied professional liability insurance coverage or rated in a higher risk class for your professional specialty? ☐ Yes ☐ No
5. Has any professional liability insurance carrier excluded any specific procedures from your coverage or advised you that it intends to terminate, reduce, or restrict your coverage? ☐ Yes ☐ No
6. Have any professional liability claims or suits ever been filed against you? ☐ Yes ☐ No
7. Do you have any current pending claims and/or lawsuits? ☐ Yes ☐ No
8. Have any professional liability suits filed against you resulted in a judgment against you or been terminated pursuant to a settlement in which you have paid damages to the plaintiff, with or without admitting liability? ☐ Yes ☐ No
9. Have you ever settled any professional liability claim against you prior to suit and admitted liability as part of such settlement? ☐ Yes ☐ No

PROFESSIONAL HISTORY:

For questions 1 through 10, have any of the following ever been or are currently:

- Under investigation, either voluntary or involuntary
- Denied
- Revoked
- Suspended
- Restricte
- Reduced or limited
- Placed on probation
- Reprimanded
- Not Renewed
- Relinquished or Terminated

PLEASE PROVIDE COMPLETE EXPLANATIONS IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED IN THE AFFIRMATIVE.

1. Medical license in any state or jurisdiction ☐ Yes ☐ No
2. Other professional registration/license in any state or jurisdiction ☐ Yes ☐ No
3. Federal DEA Registration ☐ Yes ☐ No
4. State Controlled Substance Registration ☐ Yes ☐ No
5. Membership on any hospital/healthcare facility, medical/professional staff ☐ Yes ☐ No
6. Clinical privileges ☐ Yes ☐ No
7. Participation in the Medicare/Medicaid program(s) ☐ Yes ☐ No
8. Membership in other healthcare organizations/plans (i.e. PPO, MSO, HMO, ASC) ☐ Yes ☐ No
9. Professional society memberships ☐ Yes ☐ No
10. Board certification ☐ Yes ☐ No
11. Have you ever pled guilty, pled nolo contendere, been convicted of a felony, or are you presently indicted for a felony? ☐ Yes ☐ No
12. Has any claim of sexual harassment or violation of civil rights ever been made against you that resulted in your receiving or incurring any warning, disciplinary action, or civil liability? ☐ Yes ☐ No
13. Have you ever withdrawn an application for license to practice medicine in any state or withdrawn an application for appointment, reappointment, or clinical privileges? ☐ Yes ☐ No
14. Has your membership or clinical privileges ever been voluntarily or involuntarily restricted, limited, or terminated in any fashion? ☐ Yes ☐ No
15. To your knowledge has any information pertaining to you ever been reported to the National Practitioner Data Bank? ☐ Yes ☐ No

PROFESSIONAL HISTORY: *(Continued)*

16. Have you ever been investigated, reprimanded, suspended, sanctioned, excluded, or otherwise restricted from participating in any private, federal, or state health insurance program or managed care plan (i.e. Medicare, Medicaid, etc.)? ☐ Yes ☐ No

17. Have any of your federal DEA Registrations or any state Controlled Dangerous Substance licenses ever been limited, suspended, revoked, or voluntarily relinquished, or are any proceedings currently pending? ☐ Yes ☐ No

18. Have you ever been placed on probation or subject to any disciplinary proceedings? ☐ Yes ☐ No

19. Are you currently or have you ever been a defendant in a complaint or proposed complaint for malpractice in a court before the Department of Insurance? ☐ Yes ☐ No

If yes, please explain:

PLEASE PROVIDE DETAILED DOCUMENTATION OF ALL PROFESSIONAL LIABILITY CASES.
(USE SEPARATE ATTACHMENTS IF NECESSARY)

WATSON CLINIC LLP PROVIDER AUTHORIZATION AND ATTESTATION:

I certify that all the information I have provided herein, or otherwise attached, is true and accurate (including my CV) as of the date of this application and I understand that any false information, misrepresentation or omission made or provided by me at any time will result in no further consideration of my application, or, if I have been hired, may result in immediate discharge from Watson Clinic LLP's employment, whenever it is discovered. I also understand that it is my responsibility to update this application should new information come to my attention which would make this application incomplete, inaccurate or in any way misleading.

I hereby authorize Watson Clinic the right to contact and obtain information from all sources deemed necessary to determine the current level of my training, experience, capability and competence to practice. I understand this will include a query to the National Practitioner Data Bank (NPDB) to determine if malpractice claims have been paid or settlements have been made on my behalf and whether disciplinary actions have been instituted against me by any hospital, clinic or other healthcare provider or entity. I hereby release and forever discharge from liability Watson Clinic and all its representatives from all charges, claims and causes of action of any kind relating in any manner to the information provided for seeking, gathering and using such information and all other persons, corporations or organizations for furnishing such information. I extend absolute immunity to the fullest extent, and release from any and all liability, the Watson Clinic, its authorized representatives, and any third parties for any acts performed in good faith and without malice, regarding communications, reports, records, recommendations or disclosures involving me, performed, made, requested, or received by the Watson Clinic.

I hereby authorize all third parties, including physicians, hospitals, clinics and other organizations and individuals to release the information requested by the Watson Clinic and waive all personal privilege or rights of privacy to the Watson Clinic, its committees, agents and representatives.

This application does not constitute an agreement or contract for employment. I understand that no representative of Watson Clinic, other than an authorized representative, has the authority to make any assurances to the contrary concerning the terms, conditions or duration of employment. I understand further that any such assurances must be in writing and signed by an authorized representative in order to be valid and enforceable.

A copy of this statement shall be as effective as the original. I represent and warrant that I have read and fully understand the foregoing and seek employment under these conditions.

All statements provided by me in this Physician Application for Employment are true and complete to the best of my knowledge and I will notify Watson Clinic within 10 days of any material changes to the information I have provided.

I agree that by adding my name and date is the legally binding equivalent to my handwritten signature.

Name _____ Date: _____

SUBMIT