

Application Checklist

In order for us to start the process of searching for and matching you with practice opportunities,
we must have a completed document and credential file.

- The Application**
 - Information in this packet must be complete and accurate.
 - Please complete application legibly and in ink.
 - Please answer all yes/no questions and provide an explanation when requested.
 - Initial the bottom of every page.
 - Keep a copy of the application for your records.

- The Release and Authorization Form**

- Reference List**
 (Please list at least five colleagues with whom you have worked with directly in the last twelve months. MD/DO's only for physicians. CRNAs may include CRNA or physician references)

- The W-9 Complete**
 (including name, address, and taxpayer ID number or social security number, signed and dated)

- Skills and Procedures Forms**

- Goldfish Locum Tenens Provider Agreement**

- Third Party Documentation for all completed and pending malpractice/disciplinary actions**

- Complete Direct Deposit Form**
 (please included voided check)

- Current Curriculum Vitae**
 - Must include a complete chronology of activities detailed by MM/YY dates.
 - Gaps in chronology over 30 days must be accounted for.
 - If you are a locum tenens physician, your CV must reflect all assignments during the last five years
 - **Please indicated when your CV was last updated on CV**

Supporting Documents Needed

<input type="checkbox"/> Copy of Medical School Degree	<input type="checkbox"/> Copy of DEA
<input type="checkbox"/> Copy of Internship Certificate	<input type="checkbox"/> Copy of State Controlled Substance Licenses
<input type="checkbox"/> Copy of Residency Certificate(s)	<input type="checkbox"/> Copy of ECFMG Certificate <i>(if applicable)</i>
<input type="checkbox"/> Copy of Fellowship Certificate(s) <i>(if applicable)</i>	<input type="checkbox"/> Copy of CPR cards (ACLS, BLS, etc)
<input type="checkbox"/> Copy of Board Certification(s) <i>(if applicable)</i>	<input type="checkbox"/> Current Photo
<input type="checkbox"/> Copy of all current state licenses <i>(with license # and expiration date)</i>	<input type="checkbox"/> Copy of NPI Issuance Letter
<input type="checkbox"/> Copies of CMEs from the last 3 years	<input type="checkbox"/> TB Test and Immunization Records <i>(TB Test must have been done within the last twelve months)</i>
<input type="checkbox"/> Current Certificate of Professional Liability Coverage	<input type="checkbox"/> Current NPDB *

*If you do not have a current copy, please self query yourself through <http://www.npdb-hipdb.com/welcomesq.html> and fax/email the copy in. There are two types of queries that you will receive (HIPDB & NPBD). Please send it both. We are unable to do this query for you.



Personal Liability Insurance Application

PERSONAL INFORMATION

Last Name – MD/DO	First Name	Middle Name	Maiden Name	Specialty:
				Sub-Specialty:
Home Address		City	State	Zip
				Home Number
Cell Number		Fax Number		Email Address
Social Security Number	Date of Birth	Place of Birth	Citizenship	Gender

EDUCATION/TRAINING

Undergraduate School

College or University	City	State	Country
From (Month/Year)	To (Month/Year)	Degree Received	
College or University	City	State	Country
From (Month/Year)	To (Month/Year)	Degree Received	

Medical School/Training

Medical School	City	State	Country
From (Month/Year)	To (Month/Year)	Degree Received	

Internship Training (PGY-1)

Facility	City	State	Country
Type of Internship	Name of Internship Director	From (Month/Year)	To (Month/Year)

Residency Training(PGY-II & III)

Facility	City	State	Country
Type of Residency	Name of Residency Director	From (Month/Year)	To (Month/Year)
Facility	City	State	Country
Type of Residency	Name of Residency Director	From (Month/Year)	To (Month/Year)

Fellowship Training

Facility	City	State	Country
Type of Fellowship	Name of Fellowship Director	From (Month/Year)	To (Month/Year)

EXAMINATIONS & REGISTRATIONS					
<input type="checkbox"/> USMLE <input type="checkbox"/> National Board	<input type="checkbox"/> Flex <input type="checkbox"/> State Exam	In Which State?	Number of Attempts?	Date Last Taken?	
Medicare #	Medicaid #	UPIN #	NPI #	Federal DEA #	
Are you registered with the FCVS (Federal Credentials Verification Service)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have a complete FCVS profile? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, packet ID #	
ONLY ANSWER THE FOLLOWING IF YOU GRADUATED FROM A MEDICAL SCHOOL OUTSIDE OF THE UNITED STATES, PUERTO RICO OR CANADA					
Do you have a permanent ECFMG certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did you do a Fifth Pathway? <input type="checkbox"/> Yes <input type="checkbox"/> No		ECFMG Certificate #	

LICENSURE (list all active and inactive licenses)						
State	License Number	Issue Date	Expiration Date	Controlled Substance Number	Issue Date	Expiration Date

BOARD CERTIFICATIONS		
Are you currently American Board Certified by one or more specialty boards? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Specialty Board	Date of Original Certification	Expiration Date
Name of Specialty Board	Date of Original Certification	Expiration Date
ONLY ANSWER THE FOLLOWING IF YOU ARE NOT CURRENTLY AMERICAN BOARD CERTIFIED		
Have you ever taken a specialty board examination and failed to pass? If yes, how many times? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever applied for the certification exam? If yes, when are scheduled to take the exam? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No

CERTIFICATION LIST					
ACLS	Issue Date	Exp Date	NRP	Issue Date	Exp Date
BCLS	Issue Date	Exp Date	ALSO	Issue Date	Exp Date
ATLS	Issues Date	Exp Date	PALS	Issue Date	Exp Date

MILITARY SERVICE			
Have you or are you currently serving in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Branch	Start Date (month/year)	End Date (month/year)	Status (active, honorable discharge, etc)

PROFESSIONAL LIABILITY INSURANCE HISTORY			
<i>List all carriers in the past five (5) years, you may include separate sheet, if necessary.</i>			
Current Carrier	Policy Number	Coverage Dates	
Address	City, State	Coverage Limits	Phone Number
Carrier Name	Policy Number	Coverage Dates	
Address	City, State	Coverage Limits	Phone Number
Carrier Name	Policy Number	Coverage Dates	
Address	City, State	Coverage Limits	Phone Number
Carrier Name	Policy Number	Coverage Dates	
Address	City, State	Coverage Limits	Phone Number
Carrier Name	Policy Number	Coverage Dates	
Address	City, State	Coverage Limits	Phone Number
Carrier Name	Policy Number	Coverage Dates	
Address	City, State	Coverage Limits	Phone Number
Carrier Name	Policy Number	Coverage Dates	
Address	City, State	Coverage Limits	Phone Number

MALPRACTICE CLAIMS HISTORY	
Have you ever been named in a malpractice claim, suit, or arbitration proceeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Total Number of Claims (include closed, pending and filed claims) <i>(Please complete Supplement Claim Forms for each)</i>	_____
Has any insurance carrier ever denied, cancelled, refused to renew, restrict or rate up professional liability insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any liability insurance carrier placed restrictions and/or excluded any specific procedure from your insurance coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No

DISCLOSURE QUESTIONS

If the answer is "yes" to question #3 through #18, you must provide explanation on a separate sheet of paper)

1. The essential function of a Locum Tenens physician is to provide a standard of care that is acceptable within his/her specialty. Are you capable of performing this function?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you authorized to work as an independent contractor in the United States?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you currently abusing alcohol, using illegal drugs, or failing to take legally prescribed drugs in the manner you are prescribed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you abused alcohol, used illegal drugs, or failed to take legally prescribed drugs in the manner prescribed in the past? If yes, please disclose what drugs and how recently you have used the drugs.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation? <i>(a "yes" will not automatically disqualify you from consideration for placement)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been convicted of any violation of a state or federal law relating to controlled substances? <i>(a "yes" will not automatically disqualify you from consideration for placement)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever been denied or surrendered a state or federal controlled substances certificate?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has your license to practice medicine in any state been reprimanded, sanctioned, placed on probation, curtailed, suspended, revoked, restricted, denied or voluntarily surrendered in order to avoid disciplinary action/investigation by a state medical board?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever been denied a certificate by, or the privilege of taking an examination before, any state medical board?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have your staff/clinic privileges at any hospital, health care facility, and/or clinic ever been denied, revoked, suspended, curtailed, limited, or placed under conditions restricting your practice, or voluntarily surrendered in lieu of investigation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you resigned from a position in lieu of an investigation, or have ever been terminated from employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you ever been disciplined by any state board for any violation of the Medical Practice Act or unethical conduct?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Have you ever been denied provider participation in any state or federal Medicare/Medicaid program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you ever been terminated, sanctioned, penalized by or had to repay money to any state or federal Medicare/Medicaid program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Have you ever been convicted of a violation of any federal or state narcotic law? <i>(a "yes" will not automatically disqualify you from consideration for placement)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Have you ever been disciplined by a hospital staff or an internship, residency, fellowship or other professional educational program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Is there any other issue which should be disclosed that may have an adverse impact on your ability to deliver effective Locum Tenens service?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. To your knowledge, has any information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?	<input type="checkbox"/> Yes <input type="checkbox"/> No

CONSENT

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician or dentist, firm, or professional association.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT. BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED TO ME OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I further understand and agree that I have no right to demand or expect coverage until the Company has received my completed application.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS **I WILL HAVE NO COVERAGE FOR ANY CLAIM UNDER ANY POLICY OF INSURANCE FOR WHICH I AM APPLYING.**

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance.

Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Acknowledge and Agree:

Applicant Signature

Date

Printed Name

RELEASE AND 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 Goldfish Locum Tenens 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 Goldfish Locum Tenens may introduce me to various facilities in order to provide medical services through Goldfish Locum Tenens. I agree to work in such referred facilities only through Goldfish Locum Tenens for the period described in Goldfish Locum Tenens' contract except upon payment of a reasonable recruitment fee and as otherwise provided in Goldfish Locum Tenens contract.

I authorize and release to Goldfish Locum Tenens and its agents, 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 Goldfish Locum Tenens and its agents to consult with any persons, entities, hospitals, employers, institutions and/or medical licensing boards, including, but not limited to, the Federation of State Medical Boards or the National Practitioner Data Bank, 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 Goldfish Locum Tenens from any liability arising out of any request for information, in accordance with this application, that it makes, or use 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.

Signature

Date

Print Name

Goldfish Locum Tenens
AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS (ACH CREDITS)



- Accept Direct Deposit (Complete Sections I and II)**
- Decline Direct Deposit (Complete Section II)**

Section I – Bank Information

I hereby authorize Goldfish Locum Tenens and its entities, hereinafter called COMPANY, to initiate credit entries and to initiate if necessary, adjustments for any credit entries in error to my checking and / or savings account indicated below at the depository named below.

Account Number: _____

Routing Number: _____

Checking or Savings?: _____

Name of Deposit Institution: _____

City, State: _____

Please attach a copy of a voided check.

This authority is to remain in full force and effect until COMPANY, has received written notification from me of its termination in such time and in such a manner as to afford COMPANY and Deposit Institution a reasonable opportunity to act on it.

Section II – Candidate Information

Candidate Name: _____

Address where check is to be mailed _____

Street Address

City, State Zip

Phone Number: _____

Social Security Number: _____

**If declining Direct Deposit: Checks are mailed out on a weekly basis on Friday. Please allow 7-10 business days to receive check via standard shipping times with the United States Postal Service.*

Signature _____

Date: _____

Request for Taxpayer Identification Number and Certification

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

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=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 Line 1 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
or
Employer identification number

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

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.

Sign Here	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.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,