RESET

APP Application for Employment

WATSON CLINIC LLP
Professional Services

PRACTICE SPECIALTY
REFERRED BY

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

Please attach a Resume/CV that is complete and current as of this date, including your education and the names and addresses of all employers including the dates of employment for each. ***Resume/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 (MM/YY) _____ DATE TO (MM/YY) _____

PRESENT MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

PERMANENT MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

CELL PHONE NUMBER _____ SECONDARY PHONE NUMBER _____ FAX NUMBER _____

EMAIL ADDRESS _____

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. Two others can be in your same discipline.

If training was completed more than 24 months prior, and you have been practicing professionally:
Department Chair/Supervising physician (s) required, 2 peers in the same discipline.
**These must be individuals have worked with applicant within 2-3 years.*

Peer Reference Name: _____

Title: _____ Company: _____

Phone #: _____ Email: _____

Peer Reference Name: _____

Title: _____ Company: _____

Phone #: _____ Email: _____

Peer Reference Name: _____

Title: _____ Company: _____

Phone #: _____ Email: _____

SPECIALTIES AND BOARD INFORMATION:

CERTIFYING AGENCY _____ SPECIALTY _____ CERTIFICATE # _____

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

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

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

PROFESSIONAL LICENSES:

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

STATE _____ LICENSE NUMBER _____ STATUS _____ EXPIRATION DATE _____

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DEA LICENSE NUMBER _____ 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 professional school, hospital, or health care entity during your training? ☐ Yes ☐ No

If yes, please explain: _____

_____

Please list your 2 most recent employers as a practicing provider:

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

City _____ State _____ Phone Number: _____

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

PROFESSIONAL LIABILITY: *(Continued)*

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. To your knowledge has any information pertaining to you ever been reported to the National Practitioner Data Bank? ☐ Yes ☐ No
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
15. Are you currently or have you ever been a defendant in a complaint or proposed complaint for Malpractice in the court before the department of Insurance? ☐ Yes ☐ No
16. Have you ever been placed on probation or subject to any disciplinary proceedings? ☐ Yes ☐ No
17. 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
18. Are any proceedings currently pending? ☐ Yes ☐ No

PLEASE PROVIDE COMPLETE EXPLANATIONS IF YOU ANSWERED IN THE AFFIRMATIVE TO ANY OF THE QUESTIONS LISTED ABOVE.

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 ofthis 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 NationalPractitioner 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 representativein 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 theforegoing 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 Iwill 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