



SCOTT & WHITE APPLICATION

This form can be filled out online or printed. Please enter the information in the fields, print and fax to 254-724-5655, or mail to Scott & White, Attention Jason Culp, Physician Recruitment, 2401 South 31st Street, Temple, TX 76508. The information can not be saved on your computer unless you have the full version of Adobe Acrobat Writer installed.

Name _____ Maiden/Other Name _____ Social Security Number _____

Home Address _____ City _____ State _____ Zip _____ Telephone _____

Office Address _____ City _____ State _____ Zip _____ Telephone _____

Desired Scott & White Position _____ Site (if known) _____

HIGH SCHOOL EDUCATION:

Institution _____ Address _____ Dates _____ Graduated: Yes/No _____

COLLEGE EDUCATION:

Institution _____ Address _____ Dates _____ Degree _____ Award Date _____

Institution _____ Address _____ Dates _____ Degree _____ Award Date _____

MEDICAL EDUCATION:

Institution _____ Address _____ Dates _____ Degree _____ Award Date _____

Institution _____ Address _____ Dates _____ Degree _____ Award Date _____

GRADUATE TRAINING:

Institution _____ Address _____ Training _____ Dates _____
Program Completed: Yes _____ No _____ Program Director _____

Explain: _____

Institution _____ Address _____ Training _____ Dates _____
Program Completed: Yes _____ No _____ Program Director _____

Explain: _____

Institution _____ Address _____ Training _____ Dates _____
Program Completed: Yes _____ No _____ Program Director _____

Explain: _____

Practitioner Initials _____ Date _____

BOARD CERTIFICATION/REGISTRATION:

Certified/Registration by _____ / _____
Board/Agency Certification Date/ # Expiration Date

Certified/Registration by _____ / _____
Board/Agency Certification Date/ # Expiration Date

Board Qualified _____ / _____
Board/Agency Certification Date/ # Expiration Date

Recertification _____ / _____
Board/Agency Certification Date/ # Expiration Date

PREVIOUS PRACTICE, AFFILIATIONS, WORK HISTORY: (from Residency to present)
Include military experience and furnish a copy of your DD214 if available.

Type of Practice Address Dates

Type of Practice Address Dates

Type of Practice Address Dates

Type of Practice Address Dates

LICENSURE, CERTIFICATION, REGISTRATION, CONTROLLED SUBSTANCES REGISTRATIONS:

Attach copy of each.

Medical License #	State	Issue Date	Exp. Date	Other Registration #	Number	Exp. Date
				CDS/BNDD		
				Federal DEA Reg		
				EPSDT Provider		
				Medicare Provider		
				Medicaid Provider		
				UPIN/NPI		

FOREIGN MEDICAL GRADUATES: Attach copy of certificates.

Date of ECFMG Certification: _____ Certification No. _____

Practitioner Initials _____ Date _____

INSURANCE:

1. Do you presently carry professional malpractice insurance? Yes_____ No_____

Carrier Name	Policy #	Anniversary Date	Coverage
--------------	----------	------------------	----------

(Attach copy of policy cover page with levels of coverage)

2. List all previous insurance coverage (include carrier name, carrier's address, policy # & dates covered) on a separate page.
3. Has your professional malpractice insurance ever been canceled or renewal refused? YES / NO. If yes, Please explain on a separate page.
4. Have you ever had a claim or a suit filed against you for professional liability? YES / NO. If yes, please Provide full details on a separate page.

REFERENCES: (Please include address and telephone number and email address of three references)

1. _____

2. _____

3. _____

PUBLICATIONS: (Please attach list):

SPECIAL INTERESTS – hobbies, recreation, etc.

COMMENTS:

Practitioner Initials _____ Date _____

Have any of the following at any time been, or are they currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other state?

- | | |
|---|--------------------|
| 1. Medical or professional license | Yes _____ No _____ |
| 2. DEA or CDS/BNDD registration | Yes _____ No _____ |
| 3. Hospital medical staff membership | Yes _____ No _____ |
| 4. Clinical privileges or other rights on any hospital medical staff | Yes _____ No _____ |
| 5. Employment by any hospital, institution, or the military | Yes _____ No _____ |
| 6. Professional society memberships | Yes _____ No _____ |
| 7. Participation in any private, federal, or state health insurance program
(i.e. Medicare, CHAMPUS, Medicaid) | Yes _____ No _____ |
| 8. Participation in an HMO, PPO, or any other managed care organization | Yes _____ No _____ |
| 9. Board Certification | Yes _____ No _____ |

At any time, have you ever been:

- | | |
|--|--------------------|
| 1. Convicted of a criminal offense | Yes _____ No _____ |
| 2. Convicted of a felony | Yes _____ No _____ |
| 3. Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of trial, or an accelerated rehabilitation disposition in the disposition of felony changes in my state, territory or country. | Yes _____ No _____ |

Have you ever at any time or are you currently:

- | | |
|--|--------------------|
| 1. Under indictment for any crime | Yes _____ No _____ |
| 2. The subject of an investigation by any private, federal or state health insurance program or state licensing board. | Yes _____ No _____ |
| 3. Under investigation by any state licensing board or federal agency | Yes _____ No _____ |
| 4. The subject of any adverse action reports to a state or federal databank | Yes _____ No _____ |

The Scott & White application process is multi-staged. The application may be followed by an interview. Employment by Scott & White Clinic or acceptance on staff or courtesy staff of Scott & White Memorial Hospital or acceptance as a practitioner for the Scott & White Health Plan is contingent upon confirmation and verification of professional credentials, delineation of privileges by Scott & White medical authorities and successful screening with a professional and health survey.

Scott & White believes that, in order to ensure proper care of all of our patients, we must have a drug free workplace. As part of this program, which includes all new staff members and employees, successful passage of a routine drug screen will be required as a condition of employment. Scott and White will collect a urine specimen for a drug testing sometime during the first sixty days of your employment.

I hereby agree to accept new patients from the Scott & White Health Plan (SWHP).

I hereby declare that the information given herewith in this Application is true and correct to the best of my knowledge and belief. I fully understand that any significant misstatements in, or omissions from, this Application may result in the denial of my consideration for employment or provider status by Scott & White Clinic or in my immediate termination, if I am employed or contracted by Scott & White Clinic. I understand that I have a right to review, and that I have an obligation to correct, any information submitted in this Application, and that this obligation continues if I am employed or contracted.

Signature

Date

Practitioner Initials _____ Date _____