CENTRAL NORTH ALABAMA HEALTH SERVICES, INC.
APPLICATION FOR EMPLOYMENT

Provider Staff

Central North Alabama Health Services, Inc. (CNAHSI) complies with State and Federal laws regarding equal employment opportunity. Qualified applicants are considered for all positions without regard to race, color, religion, sex, national origin, citizenship, military or marital status, age, or disability if otherwise qualified with or without reasonable accommodation.

For consideration, please answer completely and accurately. Do not reference resume.
Applications for employment will remain active for six (6) months and are kept on file for one (1) year.

(Please Print requested information in ink) **Date:** _____

PERSONAL INFORMATION

Last Name	First Name	Middle Initial	Social Security Number
Work Address	**City**	**State** / **Zip**	**Office Telephone Number** ( )
Home Address	**City**	**State** / **Zip**	**Home Telephone Number** ( )

Have you ever worked or attended school using any other name? ☐ Yes ☐ No
(This information is used for checking references only)

If yes, what is the name? _____

Dates known by this name: _____

If you are not a citizen, do you have a legal right to work in the United States? ☐ Yes ☐ No

Do you have any relatives or friends working for CNAHSI? ☐ Yes ☐ No If yes, list their name(s): _____

Have you filed an application here before? ☐ Yes ☐ No If yes, give date: _____

Have you ever been employed here before? ☐ Yes ☐ No If yes, in what capacity and date(s) of previous practice (month/year): _____

How did you learn about CNAHSI? _____

Specialty _____ Subspecialty _____

Other professional interests in practice, research, special skills, etc. _____

Do you have the ability to communicate with patients in a language other than English (including American Sign Language)? ☐ Yes ☐ No If yes, specify: _____

POSITION INFORMATION

Position you are applying for: _____

Date available: _____ Work Schedule requested: ☐ Full-Time

☐ Part-Time ☐ Contractual ☐ Other (Specify) _____

Do you have any commitments to or agreement/contract with another employer or group practice that might affect your employment with CNAHSI? ☐ Yes ☐ No If yes, explain: _____

_____

PRE-PROFESSIONAL EDUCATION

If there are any gaps in time between education, please provide information about your activities during those time. If necessary, use a separate sheet.

College or University		Date of Graduation	Degree
Address	City	State	Zip
College or University		Date of Graduation	Degree
Address	City	State	Zip

PROFESSIONAL EDUCATION

List all professional schools attended, whether or not a degree was granted. If there are any gaps in time between education, please provide information about your activities during those times. If necessary, use a separate sheet.

Professional School		Date of Graduation	Degree
Address	City	State	Zip
Professional School		Date of Graduation	Degree
Address	City	State	Zip
Professional School		Date of Graduation	Degree
Address	City	State	Zip

POSTGRADUATE TRAINING

In chronological order, list all postgraduate training (Internship, Residency or Fellowship); Institution address; Department Chair or Program Director and Dates of Service. If there are any gaps in time between training, please provide information about your activities during those times. If necessary, use a separate sheet.

Training/Specialty		Hospital/Institution		Department Chair/Program Director
Address	City	State	Zip	Dates attended (Mo/Yr) / to /
Training/Specialty		Hospital/Institution		Department Chair/Program Director
Address	City	State	Zip	Dates attended (Mo/Yr) / to /
Training/Specialty		Hospital/Institution		Department Chair/Program Director
Address	City	State	Zip	Dates attended (Mo/Yr) / to /
Training/Specialty		Hospital/Institution		Department Chair/Program Director
Address	City	State	Zip	Dates attended (Mo/Yr) / to /

HONORS

List honors or awards received during education or training: _____

CERTIFICATION/LICENSURE

List your American Specialty Board Status and attach copies of all certificates and licenses.

Name of Board	Date Passed	Recertification Date(s)
Name of Board	Date Passed	Recertification Date(s)
Board Eligible/Admissible (Currently Seeking Certification)		Date of Proposed Exam
DEA Registation Number	State of Registration	Expiration Date

List all Certification Examinations (National Boards, FLEX, SPEX, ECFMG, LMCC, etc.), date taken and date passed.

Name of Exam	Date(s) Taken	Date Passed
Name of Exam	Date(s) Taken	Date Passed
Name of Exam	Date(s) Taken	Date Passed

List all State Professional Licenses/Certificates (Past/Present).

State	License No.	Date Issued	Current Status
State	License No.	Date Issued	Current Status
State	License No.	Date Issued	Current Status
State	License No.	Date Issued	Current Status
State	License No.	Date Issued	Current Status
State	License No.	Date Issued	Current Status

PREVIOUS PRACTICE

List in chronological order all medical/dental practice experience beginning with current practice. If there are any gaps in time between employment, please provide information about your activities during those times. If necessary, use a separate sheet.

Current Practice		Dates of Practice (Mo/Yr) / to /	
Address	City	State	Zip
Reason for Leaving			
Prior Practice		Dates of Practice (Mo/Yr) / to /	
Address	City	State	Zip
Reason for Leaving			
Prior Practice		Dates of Practice (Mo/Yr) / to /	
Address	City	State	Zip
Reason for Leaving			
Prior Practice		Dates of Practice (Mo/Yr) / to /	
Address	City	State	Zip
Reason for Leaving			
Prior Practice		Dates of Practice (Mo/Yr) / to /	
Address	City	State	Zip
Reason for Leaving			
Prior Practice		Dates of Practice (Mo/Yr) / to /	
Address	City	State	Zip
Reason for Leaving			
Prior Practice		Dates of Practice (Mo/Yr) / to /	
Address	City	State	Zip
Reason for Leaving			

HOSPITAL STAFF MEMBERSHIPS AND AFFILIATIONS

List in chronological order all previous hospital affiliations beginning with current hospital affiliations. If necessary, use a separate sheet. Hospitals may be contacted prior to interview unless CNAHSI is notified otherwise.

Hospital				Type of Appointment or Privileges
Address	City	State	Zip	Dates of Appointment (Mo/Yr) / to /
Hospital				Type of Appointment or Privileges
Address	City	State	Zip	Dates of Appointment (Mo/Yr) / to /
Hospital				Type of Appointment or Privileges
Address	City	State	Zip	Dates of Appointment (Mo/Yr) / to /
Hospital				Type of Appointment or Privileges
Address	City	State	Zip	Dates of Appointment (Mo/Yr) / to /

PROFESSIONAL REFERENCES

List three (3) professionals in the same discipline who have supervised your clinical/dental practice or have worked with you professionally within the past three (3) years. References may be contacted prior to interview unless CNAHSI is notified otherwise.

1. Name		Institution or Practice Name	
Address		City State	Zip
Telephone ( )	Period of Association (Mo/Yr) / to /	Relationship	
2. Name		Institution or Practice Name	
Address		City State	Zip
Telephone ( )	Period of Association (Mo/Yr) / to /	Relationship	
3. Name		Institution or Practice Name	
Address		City State	Zip
Telephone ( )	Period of Association (Mo/Yr) / to /	Relationship	

MEMBERSHIP IN PROFESSIONAL SOCIETIES

Are you a member of or applicant to any County or State Professional Societies? ☐ Yes ☐ No If yes, give name(s) of the Society: _____

Are you a member of or applicant to any National Professional Societies? ☐ Yes ☐ No If yes, give name(s) of the Society: _____

List Professional Colleges or Academies of which you are a member:

Name	Membership Status	Date Elected
Name	Membership Status	Date Elected

CONTINUING PROFESSIONAL EDUCATION

For the past two (2) years, list: (Attach a separate sheet if necessary).

A. All postgraduate activities which you have attended or for which you have received credit;
or

B. If you have reported your continuing professional education activities to an authorized association:
   1. name of association
   2. the date when you reported your hours
   3. the number of category I hours reported
   4. the number of category II hours reported
   5. the major continuing professional education programs in which you have participated

CARDIOPULMONARY RESUSCITATION

Please attach a copy of current CPR certification.

BIBLIOGRAPHY

Attach a separate sheet, include reprints, if possible.

PROFESSIONAL LIABILITY CARRIERS

List all liability coverage since residency. If necessary, use a separate sheet.

Name and address of Professional Liability Carrier		
Policy Number	Amount of Coverage	Dates of Coverage (Mo/Yr) / to /
Name and address of Professional Liability Carrier		
Policy Number	Amount of Coverage	Dates of Coverage (Mo/Yr) / to /

Has your professional liability insurance ever been canceled, denied, revoked or not renewed? ☐ Yes ☐ No
If yes, please give full details on a separate sheet and attach to application.

Have you ever been named as a defendant in a professional liability case or are any such cases pending? ☐ Yes ☐ No

If yes, please give full details on a separate sheet and attach to application. Include any medical/dental liability judgments, awards or out-of-court settlements that have been made against you or are pending.

Have you ever practiced without professional liability coverage? ☐ Yes ☐ No

You must provide a letter from each of your present and past malpractice insurance carriers listing all claims, suits or judgments against you alleging professional negligence, and any settlements.

PROFESSIONAL LIABILITY REVIEW

If your answer to any of the following questions is "Yes," please give details on a separate sheet.

	YES	NO
1. Has your license, registration, certification, permit or authorization to practice your profession or occupation or to provide health care services of any nature either as a student, intern, resident, or in any other capacity, ever been denied, limited, restricted, reduced suspended, not renewed, revoked voluntarily relinquished, or been subject to investigation, review, reprimand, warning or any disciplinary action or probationary condition, or has any such action ever been initiated or is any such action or probationary condition, or has any such action ever been initiated or is any such action pending?	☐	☐
2. Have you ever been, or are you currently the subject of a disciplinary action or investigation by any government or private agency, court or peer review organization concerning your professional license or registration, certification, permit or authorization to provided health care services?	☐	☐
3. Have your clinical privileges, request for privileges or medical/professional staff membership or renewal thereof, at any hospital or health care facility ever been investigated, limited, restricted, reduced, suspended, revoked, denied or been subject to a warning or any disciplinary action or probationary condition, or has such an action been recommended by a medical/professional staff committee, any health care facility or governing body?	☐	☐
4. Have you ever voluntarily or involuntarily relinquished or withdrawn your request for medical/ professional staff membership or clinical privileges at any hospital or health care facility during or under the threat of investigation?	☐	☐
5. Has your professional employment or membership in a professional organization ever been subject to disciplinary proceedings, denied, limited, restricted, reduced, suspended, revoked, not renewed, voluntarily relinquished during or under threat of termination or terminated for any reason?	☐	☐
6. Have you ever been notified that a report, complaint or other filing regarding your practice or a malpractice payment made on your behalf has been bade to the National Practitioner Data Bank or any State Licensing Board?	☐	☐

	YES	NO
7. Has your Drug Enforcement Agency registration or other controlled substance authorization ever been investigated, reviewed, limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your registration during or under the threat of an investigation or are any such actions pending?	☐	☐
8. Have you ever been named as a party in any criminal proceeding or been convicted of a criminal offense? Each case will be judged on its own merits with respect to its effect on your professional qualifications and competence.	☐	☐
9. Have your fees, quality of care or other practices ever been subject to investigation or action, including fraud or abuse proceedings by a government agency or third party payer, including but not limited to suspension, sanction or other restriction by any private, federal or state health payment program, including Medicare or Medicaid?	☐	☐
10. Is there any additional information which may possibly influence the acceptance of your application for employment, licensure, or hospital privileges; which may influence the performance of your professional duties or which may reflect unfavorably upon your ability to interact with patients, hospital employees, or medical/dental staff?	☐	☐

IN CASE OF EMERGENCY

In case of accident or other emergency, whom should we contact?

Name: _____

Home Address: _____ Telephone No.: _____
Street City State

Work Address: _____ Telephone No.: _____
Street City State

Work Hours: _____ Department: _____

If considered for employment, will you consent to a post-offer, pre-employment physical examination including blood test and urinalysis? **(Note: This analysis may include testing for controlled substances - illegal drugs).**

☐ Yes ☐ No

The results of any physical examination will be considered for employment purposes only as it relates to the ability to perform the essential functions of the position for which you would be employed. Further, post employment exams are required only if fitness for duty is at issue. All results of physical exams are kept confidential.

PLEASE READ CAREFULLY BEFORE SIGNING THIS APPLICATION

I understand that the Chief Health Services Officer of CNAHSI is responsible for the evaluation of my professional competence and qualifications, and has the obligation to inquire into my professional training, experience, professional conduct and judgment and to make appropriate recommendations to the President and Chief Executive Officer and governing Board of CNAHSI. By filing this application, I agree to be bound by the ethics of the medical profession, all applicable federal, state and local laws and ordinances, and CNAHSI's Practice Management Guide. I agree that it is my duty and ethical responsibility as an individual provider and as an employee of CNAHSI to cooperate with, and assist colleagues in evaluating not only my professional qualifications but also those of my colleagues. I agree to appear before professioanl committees for interviews and inquiries at reasonable times and places.

It is agreed and understood that this application for employment in no way obligates the Company to employ me. Regardless of whether or not I become employed by CNAHSI, I recognize that this application is not and should not be considered as a contract of employment. I agree and understand that employment at CNAHSI is on an at-will basis and that my employment may be terminated with or without cause, and without notice, at any time, by either the Company or me. It is agreed and understood by me that participation in any of the benefit programs of the Company, the Employee Handbook/Personnel Policies or other statements of Company policy is not a contract and cannot create a contract of employment for any definite duration. I further agree and understand that no CNAHSI employee or representative has the authority to enter into a contract regarding duration or terms and conditions of employment other than the President and Chief Executive Officer and then only by means of a written document.

I hereby affirm that all of the information given by me on this application (and accompanying curriculum vitae) is true and correct to the best of my knowledge and belief and is furnished in good faith. I understand that I have the burden of producing adequate information for proper evaluation of this application. I also agree to provide updated current information regarding all questions on this application form as such information becomes available and such additional information as may be requested by CNAHSI or its authorized representatives. I understand that failure to produce this information or additional information will prevent my application from being evaluated and acted upon.

The information given in this application is accurate and fairly represents the current level of my training, experience, capability and competence to perform the duties of employment. I understand that false or misleading statements or significant omissions of any kind on this application or supplemental forms are sufficient cause for my being denied employment or my immediate suspension or dismissal if discovered at a later date.

I understand that any offer of employment is contingent upon my furnishing medical information regarding my health status and demonstrating that my physical and mental health condition is adequate to perform the essential duties of the privileges and/or position involved through a post-offer medical examination (which may include drug screening). Further, I understand that it is the policy of this Company that employees be drug free. I understand that as a condition of my employment, I may be tested for controlled substances from time to time and that a positive test result may be grounds for termination and denial of worker's compensation and/or unemployment benefits.

I understand that any offer of employment is also contingent upon my ability to provide documentation required by the Immigration Reform and Control Act og 1986 to substantiate that I am legally authorized to work in the United States.

If employed, I agree to abide by all Company policies and regulations. I also understand the Company has a right to modify its policies without notice to me.

AUTHORIZATION FOR RELEASE OF INFORMATION

By making this application for employment at CNAHSI, I consent to the exchange of information and documents between any and all persons, institutions, individuals, licensing agencies, and general and state governmental bodies with whom I have been associated which are material to evaluating and monitoring my professional practices, qualifications, competence, morality or ethics.

I hereby release CNAHSI and its representative(s) from legal liability for all acts performed and statements made in good faith in connection with evaluating my application and credentials and in monitoring my professional activities. I further release from any legal liability all individuals, organizations, institutions and former employers who provide information to CNAHSI in good faith and without malice, including what may considered otherwise privileged or confidential information.

I hereby affirm that this application was completed by me, and that all entries and information on it are true and complete, to the best of my knowledge.

Date	Applicant's Signature