

**MAXIM is an equal opportunity Employer and does not discriminate against otherwise qualified applicants on the basis of race, color, creed, religion, ancestry, age, sex, marital status, national origin, disability or handicap, veteran status or any other classification protected under applicable laws.**



## **APPLICATION/CHECKLIST INSTRUCTIONS:**

1. The application may be completed, either on-line, or printed out and legibly completed by hand in blue/black ink, or by typing onto the document.
2. If hard copy is completed, we suggest that before you begin, you make a copy of the blank form. If you need more space than what is provided, please feel free to add additional sheets copied from the original.
3. The application may either be completed legibly in blue/black ink or by typing the document. Upon completion, print and sign the form in blue/black ink.
4. Please complete each question/field. For those that do not apply, please indicate N/A.
5. If there are any questions that you do not currently have the answer for, please obtain and complete before submitting the application. **INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED.**
6. The information contained in this application will be used to present your credentials to our clients and as your application for hospital affiliation/privileges and licensure, as applicable. Therefore it is imperative that the information be complete and accurate. Please do not indicate "See CV", in lieu of completing.
7. Please sign and date the **AUTHORIZATION TO RELEASE INFORMATION & AFFIRMATION/ATTESTATION.**
8. By initialing each page of the attached application, you are certifying that the information is true, correct and complete to the best of your knowledge and belief.
9. Be sure to make a copy of your completed form for your records.

### **Document Checklist**

- \*Completed/Signed Application
  - \*Completed/signed Criminal Background Check Release Form
  - \*A copy of your current/complete Curriculum Vitae/Resume (in month/date format), with explanations of any gaps in work history over three (3) months.
  - \*Skills Checklist
- \*Required at a minimum for preliminary verifications***
- Copies of all State Licenses ever held (If you do not have a copy of a particular license, we will accept a copy of the certificate given by the State Licensing Board when you were first licensed.)
  - Copy of your current Drug Enforcement Administration (DEA) Certificate
  - Copies of any current State Controlled Dangerous Substance (CDS) Certificates
  - Copies of proof of completion from all Education/Training (Professional/Medical School, Internships, Residencies, Fellowships, Graduate Degrees, etc.)
  - Copy of Education Commission of Foreign Medical Graduates (ECFMG) certificate, if applicable
  - Copies of Certificates relevant to your area of expertise (i.e. ABMS, ABPS, NCCPA, ANCC, MQSA)
  - Copies of Life Support Certifications, as applicable (BLS, ACLS, ATLS, PALS, NRP)
  - A list of Continuing Education Credits for past three years (You may include copies, but the list is required.)
  - Copy of National Practitioner Identifier (NPI) Acknowledgement/Request Form and Email Confirmation Notice
  - Three letters of professional reference from other physicians who can attest to your clinical capabilities within the past year



**PERSONAL INFORMATION:**

Full Name		Last		First		Middle	
Degree/Title		Other Name(s) Used/Reason					
Social Security Number		/ /		NPI #			
Specialty			Sub-Specialty/Expertise				
Home Street Address							
City/State/Zip		City		State		Zip	
Home Phone Number		( ) -		Cell Phone Number		( ) -	
Pager/Beeper Number		( ) -		Fax Number		( ) -	
Email Address		@					
Emergency Contact		Name		Phone	( ) -		
Can you perform the essential functions of the position for which you are applying?							<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, please explain:							
Only U.S. Citizens or aliens who have a legal right to work in the U.S. are eligible to work for Maxim. Can you, upon hire provide genuine documentation establishing your identity and eligibility to legally work in the United States?							<input type="checkbox"/> Yes <input type="checkbox"/> No

**PROFESSIONAL REFERENCES:**

PLEASE SELECT 3 REFERENCES WITH RECENT KNOWLEDGE OF YOUR CURRENT COMPETENCY, WITHIN THE PAST YEAR. AT LEAST ONE OF THESE REFERENCES SHOULD BE A SUPERVISOR, MEDICAL DIRECTOR, OR CHIEF OF STAFF AT YOUR LAST POSITION.

Name/Title		Address					
Phone	( ) -	Fax	( ) -	Email	@		
Phone	( ) -	Fax	( ) -	Email	@		
Phone	( ) -	Fax	( ) -	Email	@		



**LICENSES/CERTIFICATION:**  
(All licenses ever held, regardless of current status)

State License	Number	Date Issued	Expiration
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

Other		Number	Date Issued	Expiration
DEA	<input type="checkbox"/> N/A		/ /	/ /
State CDS	<input type="checkbox"/> N/A		/ /	/ /
State CDS	<input type="checkbox"/> N/A		/ /	/ /
ECFMG	<input type="checkbox"/> N/A		/ /	/ /
Board Certified?	<input type="checkbox"/> N/A		/ /	/ /
If not Board Certified are you still Board qualified?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If qualified, Estimated Date of Certification?	/ /
Name of Specialty Board(s)	_____			

Current Life Support Certification	<input type="checkbox"/> BLS Expiration / /	<input type="checkbox"/> ACLS Expiration / /	<input type="checkbox"/> ATLS Expiration / /	<input type="checkbox"/> PALS Expiration / /	<input type="checkbox"/> NRP Expiration / /
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**PRIVATE/CONFIDENTIAL - DISCLOSURE:**

**IMPORTANT INSTRUCTIONS:** Please answer all questions. DO NOT LEAVE ANY BLANK - If not applicable indicate, "N/A". If you answered "YES" to ANY question below, YOU ARE REQUIRED to provide all documentation related to the action(s) including attorney correspondence, court documents, supporting expert testimony/consultations, etc.

In addition, you are asked to attach all related documentation such as non-privileged attorney correspondence, court/hearing documents, insurance carrier history reports, supporting expert testimony/consultation, etc. You may also forward a personal written narrative, addressed to our attention.

1) Have any of your professional licenses, in <b>ANY</b> state, <b>EVER</b> been limited, sanctioned, voluntarily/involuntarily restricted, denied, revoked, suspended, surrendered, subjected to a consent order, placed on probation, withdrawn, conditioned or cancelled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Has your DEA license or state CDS certification <b>EVER</b> been voluntarily or involuntarily suspended, restricted, revoked, surrendered, withdrawn, terminated, conditioned, denied, or limited?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Have any of your board certifications <b>EVER</b> been suspended, revoked, withdrawn, terminated or voluntarily surrendered?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4) Have your privileges/affiliation at <b>ANY</b> hospital, facility, or managed care organization <b>EVER</b> been voluntarily or involuntarily surrendered, denied, suspended, revoked, restricted, limited, terminated, withdrawn or placed on probation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Have you <b>EVER</b> been placed on probation, asked to resign or actually resigned from an internship, residency, or <b>ANY</b> other training program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6) Have you <b>EVER</b> been named as a defendant in <b>ANY</b> criminal case, other than misdemeanor traffic violation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7) Has your malpractice insurance <b>EVER</b> been cancelled, suspended, restricted, limited, special rated, or not renewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8) Have you <b>EVER</b> been suspended from or sanctioned by the Medicare , Medicaid or any other program funded with federal, state or local monies, or has your participation status in any such program <b>EVER</b> been modified (terminated, suspended, restricted, revoked, limited, cancelled, conditioned, or <b>ANY</b> other adverse action)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9) Have you <b>EVER</b> been the subject of a focused review by a peer review organization or similar agency including, but not limited to, Medicare, Medicaid, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10) Have you <b>EVER</b> been sanctioned or otherwise disciplined for a violation of ethical standards, rules or guidelines by a professional organization, licensing board, or health care organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11) Has information pertaining to you <b>EVER</b> been reported to the National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protection Data Bank (HIPDB)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12) Have you <b>EVER</b> received a sanction, reprimand, censure or similar action from a regulatory agency (e.g., CLIA, OSHA, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13) Are you or have you <b>EVER</b> been engaged in the illegal or improper use. Prescription or distribution of drugs or other CDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14) Have you <b>EVER</b> been sanctioned, reprimanded, censured or otherwise disciplined in <b>ANY</b> manner by any federal, state or local licensing authority or other professional board or peer committee for conduct related to the <u>use or abuse of alcohol or drugs</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15) Have you ever been convicted of a crime other than a minor traffic infraction? If so, when, where, and what was the disposition of the case?  _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

*IN THE EVENT OF HIRE, YOU ARE RESPONSIBLE FOR ONGOING DISCLOSURE, BETWEEN CREDENTIALING CYCLES, OF ACTIONS TAKEN RELATED TO THE DISCLOSURE QUESTIONS ABOVE, THAT CHANGES YOUR RESPONSE(S) ABOVE.*



EDUCATION/TRAINING:

<b>UNDERGRADUATE TRAINING</b>		
College or University	From: / /	To: / /
City	State	Degree
College or University	From: / /	To: / /
City	State	Degree

<b>MEDICAL EDUCATION</b>		
College or University	From: / /	To: / /
City	State	Degree
College or University	From: / /	To: / /
City	State	Degree

<b>INTERNSHIP/RESIDENCIES/FELLOWSHIPS</b>		
College or University	From: / /	To: / /
City	State	Specialty/Area of Study
College or University	From: / /	To: / /
City	State	Specialty/Area of Study
College or University	From: / /	To: / /
City	State	Specialty/Area of Study
College or University	From: / /	To: / /
City	State	Specialty/Area of Study



### AFFILIATIONS/WORK HISTORY:

BEGIN WITH MOST CURRENT. PLEASE BE SURE TO INCLUDE A FAX NUMBER AND EMAIL ADDRESS. FOR TEMPORARY/LOCUM TENENS POSITIONS YOU MUST INCLUDE EACH INDIVIDUAL ASSIGNMENT FOR VERIFICATION PURPOSES. ANY GAPS OVER THREE MONTHS REQUIRE EXPLANATION.

Facility/Employer		Address			
1)					
Contact		Fax	( ) -	Email	@
Phone	( ) -	From	/ /	To	/ /
2)					
Contact		Fax	( ) -	Email	@
Phone	( ) -	From	/ /	To	/ /
3)					
Contact		Fax	( ) -	Email	@
Phone	( ) -	From	/ /	To	/ /
4)					
Contact		Fax	( ) -	Email	@
Phone	( ) -	From	/ /	To	/ /
5)					
Contact		Fax	( ) -	Email	@
Phone	( ) -	From	/ /	To	/ /
6)					
Contact		Fax	( ) -	Email	@
Phone	( ) -	From	/ /	To	/ /
7)					
Contact		Fax	( ) -	Email	@
Phone	( ) -	From	/ /	To	/ /
8)					
Contact		Fax	( ) -	Email	@
Phone	( ) -	From	/ /	To	/ /
<p><b>Please list any other experience, skills, or other qualifications which you believe should be considered in evaluating your qualifications for providing services for Maxim. In addition, please indicate any prior military service which you would like to have considered in connection with your application.</b></p>					

**COPY/DUPLICATE THIS PAGE AS NEEDED TO PROVIDE COMPLETE INFORMATION.**



**AUTHORIZATION TO RELEASE INFORMATION & AFFIRMATION/ATTESTATION:**

I authorize Maxim Healthcare Services, Inc., d/b/a Maxim Staffing Solutions, Maxim Government Services, LLC, Maxim Physician Resources, LLC, and their affiliated companies, together with their respective employees, affiliates, subsidiaries, agents, or related entities (collectively "MAXIM"), to consult with and obtain any necessary information in connection with my application from any available source, including, but limited to, the following: hospitals and other health care organizations; education and training institutions; malpractice carriers; licensing boards; professional organizations; managed care organizations; employers; peers; and other persons, and to obtain and verify such information. I hereby release, remise and discharge MAXIM from any and all liability for acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my qualifications and competency; and,

I consent to the release by any entity or person to MAXIM of any and all information within his, her or its possession that may be reasonably relevant to an evaluation of my professional competency, character, and moral/ethical qualifications, including any information relating to any adverse/disciplinary action, suspension, termination, or limitation of privileges, and I hereby release, remise and discharge any and all such persons or entities providing such information from any and all liability for doing so.

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I certify that each of the answers given and the information provided herein are true, correct and complete to the best of my knowledge, information and belief. I also authorize investigation of all statements contained in this application as may be necessary in arriving at any decisions relating your status with MAXIM. I understand that the falsification or omission of any relevant information may result in my failure to obtain work with MAXIM. I understand that false or misleading information given in my application, supporting documentation, or interview(s) may result in discharge. I also, understand, that I am required to abide by all rules and regulations of MAXIM.

Furthermore, in the event of hire by MAXIM, I am required to inform MAXIM of any adverse actions taken against me while working for MAXIM, including but not limited to, malpractice activity, criminal activity, license investigations/actions, within 30 days of the date of the action or the date of my receipt of such information, as appropriate. I must also provide any related supporting information/documentation. I understand this information will be used in evaluating my qualifications and competency for consideration of continued opportunity with MAXIM.

I understand that any information provided by me that is not publicly available will be treated as confidential by MAXIM, but that MAXIM shall not have any obligation to treat any information obtained from third parties in the course of its inquiry as confidential or private.

"UNDER CERTAIN STATE LAWS, AN EMPLOYER MAY NOT REQUIRE OR DEMAND, AS A CONDITION OF EMPLOYMENT, PROSPECTIVE EMPLOYMENT, OR CONTINUED EMPLOYMENT, THAT AN INDIVIDUAL SUBMIT TO OR TAKE A LIE DETECTOR OR SIMILAR TEST."

x \_\_\_\_\_ / /  
APPLICANT SIGNATURE DATE

\_\_\_\_\_  
PRINT FULL NAME / TITLE