4692 Brownsboro Road
Winston-Salem, NC 27103
Office Phone: (336) 251-1114
Office Fax: (336) 251-1116

PROVIDER APPLICATION

NURSE PRACTITIONER/PHYSICIAN ASSISTANT

Full-Time Available Date ____________________
Part-Time Available Date: ____________________
Geographical Preference: ____________________
Salary Expectation: ____________________

How Did You Learn About Us? Existing PEC Employee Name ____________________
¤ Advertisement ¤ Friend ¤ Inquiry ¤ Employment Agency ¤ Relative ¤ Other

PERSONAL INFORMATION

Last Name________________________ First Name __________________ Middle Name _________ MD/DO/NP/PA/RN

Home Address _________________________ City____________________ State__________ Zip_________

Office Address _________________________ City____________________ State__________ Zip_________

Home Phone (_____)_____________________ Home Fax (____)_________________ Cell (____)________________

Office Phone (_____)_____________________ Office Fax (____)_________________ Pager (____)________________

E-Mail ____________________________ NPI# _________________________

Citizenship _____________________ Residency Status ___________ Other Name(s) Used Legally ______________

COLLEGE/UNIVERSITY EDUCATION

College/University____

Address ____

City ___________________ State_________ Zip _______ Degree _______________ Year of Graduation _________

NURSE PRACTIONER/PHYSICIAN ASSISTANT TRAINING

Medical School ____

Address ____

City ___________________ State_________ Zip _______ Degree ____________ From_________ To_________

OTHER GRADUATE TRAINING

Medical School ____

Address ____

City ___________________ State_________ Zip _______ Degree ____________ From_________ To_________

CERTIFICATIONS

Board Certified ☐ YES ☐ NO Specialty______________ Certifying Board_____________ Expiration Date__________________

Board Certified ☐ YES ☐ NO Specialty______________ Certifying Board_____________ Expiration Date__________________

ACLS Certified ☐ YES ☐ NO Exp. Date _____________ ATLS Certified ☐ YES ☐ NO Exp. Date _____________

CAQ Certified ☐ YES ☐ NO Exp. Date _____________ CMD Certified ☐ YES ☐ NO Exp. Date _____________

MILITARY

Branch of Service _____________________ From__________ To_________ Type of Discharge_______________ Status__________

LICENSURE (PLEASE LIST ALL MEDICAL LICENSES HELD, BOTH ACTIVE AND INACTIVE.)

State ___________________ License # _______________________ Issue Date _______________ Exp. Date________________

State ___________________ License # _______________________ Issue Date _______________ Exp. Date________________

State ___________________ License # _______________________ Issue Date _______________ Exp. Date________________

Federal DEA # __________________ Exp Date _______________ State DEA # _____________ Exp Date_________________

PROFESSIONAL EXPERIENCE

Facility _______________________________________ Type (SNF, ALF, IC, CCRC) From _____________ To ______________

Address ____ City _________________________ State___________ Zip ________

Patient Volume ____________________________________ Hours Worked in Facility Per Week _________________________________

PROFESSIONAL EXPERIENCE

Facility _______________________________________ Type (SNF, ALF, IC, CCRC) From _____________ To ______________

Address ____ City _________________________ State___________ Zip ________

Patient Volume ____________________________________ Hours Worked in Facility Per Week _________________________________

PROFESSIONAL EXPERIENCE

Facility _______________________________________ Type (SNF, ALF, IC, CCRC) From _____________ To ______________

Address ____ City _________________________ State___________ Zip ________

Patient Volume ____________________________________ Hours Worked in Facility Per Week _________________________________

REFERENCES

List the names and addresses of two professionals who have personal knowledge of your clinical skills, ethical character and ability to work with others. These references must be from sources such as medical director, chief of staff, program director and practitioners with whom you have worked closely over a reasonable period of time.

Name ____ Specialty ____________ Relationship ______________________________

Address _______________________________________ Phone ____

City/State/Zip __________________________________ Fax/Email ____

REFERENCES (CONTINUED)

Name ________________________ Specialty __________ Relationship ____________________

Address ________________________ Phone ________________________

City/State/Zip ________________________ Fax/Email ________________________

DOCUMENTS TO ENCLOSE – ATTACH COPIES WITH THIS COMPLETED APPLICATION

☐ Current Curriculum Vitae

☐ Board Certificate

☐ State Medical License

☐ NPI Number and Confirmation Notice

ADDITIONAL INFORMATION

IF YOUR ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES", PLEASE PROVIDE US WITH DETAILS ON THE ATTACHED NARRATIVE SUMMARY FORM

1. Has your license to practice medicine in any jurisdiction ever been surrendered, limited, suspended, revoked, subject to probationary conditions, or, are proceedings currently pending? YES ☐ NO ☐
2. Have you ever been denied a medical license? YES ☐ NO ☐
3. Have you ever surrendered a narcotics registration, or, has one ever been limited, suspended, or revoked? YES ☐ NO ☐
4. Have you ever been refused membership on a hospital medical staff? YES ☐ NO ☐
5. Have your privileges at any hospital ever been suspended, revoked, denied, or, not renewed? YES ☐ NO ☐
6. Has your request for specific clinical privileges ever been denied, or, granted with limitations? YES ☐ NO ☐
7. Have you ever been placed on probation during your internship, residency, or fellowship? YES ☐ NO ☐
8. Have you ever been denied membership, renewal thereof, or, been subject to disciplinary action in any medical organization? YES ☐ NO ☐
9. Have you ever been arrested, charged and/or convicted of a misdemeanor or felony? YES☐ NO ☐
10. Are you aware of any disciplinary actions pending against you? YES ☐ NO ☐
11. Have you ever had any policy for medical malpractice insurance denied, cancelled, or, non-renewed? YES ☐ NO ☐
12. Have any claims or suits for malpractice been made against you? YES ☐ NO ☐
    If "yes", please attach a "Claim/Incident Report" form for each incident.
13. Have you ever been excluded from any federally funded third party payor program? YES ☐ NO ☐

AUTHORIZATION AND RELEASE

I hereby authorize PEC Management, Inc. PEC, its employees, representatives and associates to obtain references and verifications in connection with the processing of this application. By signing this application, I also authorize PEC to consult with employees, medical staff members of any healthcare institution with whom I have been affiliated, both past and present, including malpractice insurance carriers, state medical boards, private practitioners, medical schools, the national practitioner data bank, or any other individuals or institutions that may have information regarding my work record, education, training, clinical competency or any other evaluations.

I hereby release and discharge PEC and any other individuals or organizations providing such information and any and all persons, employees, representatives or agents of any of the entities listed above from any and all liability or claims of any nature in connection with the information furnished hereunder. I further consent to the release of the information obtained to your client hospitals, clinics and health care providers. I understand that it may be difficult to obtain the background information unless it is solicited in a confidential manner.

I understand and agree that I will not have access to this information and I waive any right of access to such information that I may have under the laws of any state or of the United States except as may be required by court order. A copy of this Authorization and Release may be provided to each individual, hospital or organization where information on my credentials is sought and shall remain in effect until specifically revoked in writing by me.

____ _______________
NAME OF APPLICANT (Print) MD/DO/PA/NP/RN

____ _____________
SIGNATURE OF APPLICANT DATE