



**PROVIDER APPLICATION  
PHYSICIANS**

Full-Time Available Date \_\_\_\_\_  
Part-Time Available Date: \_\_\_\_\_  
Geographical Preference: \_\_\_\_\_  
Salary Expectation: \_\_\_\_\_

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

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 \_\_\_\_\_

**MEDICAL EDUCATION**

Medical School \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Degree \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

**INTERNSHIP (PLEASE LIST ALL INSTITUTIONS. USE SEPARATE SHEET IF NECESSARY.)**

Specialty \_\_\_\_\_ Hospital \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_ Program Director \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Was this training program successfully completed?  YES  NO If "NO", please provide details on attached Narrative Summary Form

**RESIDENCY (PLEASE LIST ALL INSTITUTIONS. USE SEPARATE SHEET IF NECESSARY.)**

Specialty \_\_\_\_\_ Hospital \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_ Program Director \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Was this training program successfully completed?  YES  NO If "NO", please provide details on attached Narrative Summary Form

**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 \_\_\_\_\_

**LONG TERM CARE EXPERIENCE**

Facility \_\_\_\_\_ Type (SNF, ALF, IC, CCRC) \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient Volume \_\_\_\_\_ Hours Worked in Facility Per Week \_\_\_\_\_

**LONG TERM CARE EXPERIENCE**

Facility \_\_\_\_\_ Type (SNF, ALF, IC, CCRC) \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient Volume \_\_\_\_\_ Hours Worked in Facility Per Week \_\_\_\_\_

**LONG TERM CARE 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 \_\_\_\_\_

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