BAYSIDE EMERGENCY PHYSICIANS, *P.A.*
500 Dr. Martin Luther King Jr St N,
Suite 304
St. Petersburg, FL 33705
Phone (727) 210-5253 Fax (727) 290-4323

Physician Extender Application for Employment

Applications are considered for all positions without regard to race, color, religion, gender, national origin, ethnicity, age, marital status, veteran status, or disability. This application is not a contract or a guarantee of employment.

PLEASE PRINT

Today's Date_____

IDENTIFYING INFORMATION

Name in Full	
Current Address	
City and State, Zip	
Home Phone Number (s)	
Cellular Phone Number(s)	
Work Phone Number(s)	
Best Number to Reach You During the Weekday	
Fax Number	
Email	
Are you legally authorized to work in the United States?	
Current Position	Company/Hospital Name
City, State, Zip	
May we contact your current employer?	
Fluent Languages	
Expected Rate of Pay, Salary	
Are you willing to work the required work schedule?	
Are you looking for a full-time or part-time position?	
Are you willing to work at more than one facility?	
Date available for work	

Applicant's Name _____ Applicant's Initials _____

EDUCATION

Undergraduate College
Degree
Medical School
Degree

CONTINUING MEDICAL EDUCATION

List in detail postgraduate courses you have completed which are related to Emergency Medicine and Trauma

LICENSES AND CERTIFICATIONS

Florida Medical License Number (attach a copy)	Exp. Date
Are you BLS certified? (attach a copy if yes)	Exp. Date
Are you a BLS Instructor? (attach a copy if yes)	Exp. Date
Are you PALS certified? (attach a copy if yes)	Exp. Date
Are you a PALS Instructor? (attach a copy if yes)	Exp. Date

(Please provide at least 10 years of professional experience, if applicable.)

EMERGENCY DEPARTMENT EXPERIENCE

Employer/Hospital	Dates Employed		Work Performed
Address	From Month/Yr.	To Month/Year	
City State Zip			
Phone			
Job Position	Base Hourly Rate/Salary		
Name of Medical Director/Supervisor	Starting	Final	
Reason for Leaving			

Employer/Hospital	Dates Employed		Work Performed
Address	From Month/Yr.	To Month/Year	
City State Zip			
Phone			
Job Position	Base Hourly Rate/Salary		
Name of Medical Director/Supervisor	Starting	Final	
Reason for Leaving			

Applicant's Name _____ Applicant's Initials _____

EMERGENCY DEPARTMENT EXPERIENCE

Employer/Hospital	Dates Employed		Work Performed
Address	From Month/Yr.	To Month/Year	
City State Zip			
Phone			
Job Position	Base Hourly Rate/Salary		
Name of Medical Director/Supervisor	Starting	Final	
Reason for Leaving			

Employer/Hospital	Dates Employed		Work Performed
Address	From Month/Yr.	To Month/Year	
City State Zip			
Phone			
Job Position	Base Hourly Rate/Salary		
Name of Medical Director/Supervisor	Starting	Final	
Reason for Leaving			

Employer/Hospital	Dates Employed		Work Performed
Address	From Month/Yr.	To Month/Year	
City State Zip			
Phone			
Job Position	Base Hourly Rate/Salary		
Name of Medical Director/Supervisor	Starting	Final	
Reason for Leaving			

NON-EMERGENCY MEDICAL EXPERIENCE

Employer/Hospital	Dates Employed		Work Performed
Address	From Month/Yr.	To Month/Year	
City State Zip			
Phone			
Job Position	Base Hourly Rate/Salary		
Name of Supervisor	Starting	Final	
Reason for Leaving			

Employer/Hospital	Dates Employed		Work Performed
Address	From Month/Yr.	To Month/Year	
City State Zip			
Phone			
Job Position	Base Hourly Rate/Salary		
Name of Supervisor	Starting	Final	
Reason for Leaving			

Applicant's Name ________________________________ Applicant's Initials _______

PROFESSIONAL REFERENCES

(List below names of your current Supervising Physician and 3 practitioners of the same specialty – ie PA for PA, ARNP for ARNP who are familiar with and knowledgeable of your current competence (Within the last 12 months) and ability to perform the clinical privileges requested .

1. Name, Title, and Position	
Phone Number	
Email Address	
Address	City, State, Zip
How long have you known this person?	
How do you know this person?	
2. Name, Title, and Position	
Phone Number	
Email Address	
Address	City, State, Zip
How long have you known this person?	
How do you know this person?	
3. Name, Title, and Position	
Phone Number	
Email Address	
Address	City, State, Zip
How long have you known this person?	
How do you know this person?	
4. Name, Title, and Position	
Phone Number	
Email Address	
Address	City, State, Zip
How long have you known this person?	
How do you know this person?	

Applicant's Name _____ Applicant's Initials _____

ANSWER THE FOLLOWING QUESTIONS AND PROVIDE DETAILS FOR ANY "YES" ANSWERS

1. Has your Medical License in any jurisdiction ever been limited, suspended, or revoked?

2. Have your privileges at any location ever been suspended, diminished, or not renewed?

3. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization?

4. Does your name appear in the Insurance Data Bank? If so, how many times?

5. Has any Professional Liability Insurance ever been denied, canceled, or renewal refused?

6. Have you ever had involvement as a defendant in civil litigation involving assault/battery, intentional torts and/or any offense related to the practice of medicine?

7. Have you ever had any administrative sanctions or been suspended from participation in Title 18 (Medicare) or Title 19 (Medicaid), or do you have any actions pending against you in this regard?

8. Have you ever been charged with violating COBRA/OBRA regulations?

9. Have you ever been discharged or forced to resign for misconduct or unsatisfactory performance? If yes, give details, including the name and address and/or telephone number of the employer who terminated your employment and the reason you were told that your employment was being terminated:

10. Do you agree that the reason given for your termination was valid?

Applicant's Name _____ Applicant's Initials _____

PLEASE CHECK THE PROCEDURES YOU HAVE PERFORMED

Evaluation, stabilization, and initial treatment in the Emergency Care Center of:

- ❑ Consultation and/or care of patients with complex, complicated, or difficult problems in emergency care
- ❑ Emergency cardiopulmonary and traumatic resuscitations
- ❑ Abdominal and gastrointestinal disorders
- ❑ Cardiovascular disorders
- ❑ Cutaneous disorders
- ❑ Disorders related to the immune systems
- ❑ Disorders caused by biological agents
- ❑ Urogenital disorders
- ❑ Disorders due to chemical and environmental agents
- ❑ Hematological disorders
- ❑ Hormonal, metabolic, and nutritional disorders
- ❑ Disorders of the head and neck
- ❑ Disorder primarily presenting in infancy and childhood
- ❑ Musculoskeletal disorders
- ❑ Nervous system disorders
- ❑ Psychobehavioral disorders
- ❑ Thoracic-respiratory disorders

Skills and procedures

- ❑ ACLS, ATLS Procedures
- ❑ Anesthesia; intravenous (upper extremity), local, and regional
- ❑ Anoscopy
- ❑ Arthrocentesis
- ❑ Bladder catheterization suprapubic and transurethral
- ❑ Cannulation: artery and vein
- ❑ Cardiac defibrillation
- ❑ Cardiac massage closed
- ❑ Cardiac massage open
- ❑ Cardiac pacing: external, transthoracic, and transvenous
- ❑ Cardioversion
- ❑ Central venous access: jugular, peripheral, subclavian, femoral, and cutdowns
- ❑ Conscious sedation
- ❑ Cutdowns
- ❑ Cricothyrotomy
- ❑ Culdocentesis
- ❑ Delivery of a newborn
- ❑ EKG preliminary interpretation
- ❑ Endotracheal intubation: oral and nasal
- ❑ Esophageal obturator airway insertion
- ❑ Foreign body removal
- ❑ Fracture (simple)/dislocation reduction
- ❑ Gastric lavage
- ❑ Incision-drainage
- ❑ Intracardiac injection
- ❑ Laboratory studies and interpretation
- ❑ Laryngoscopy
- ❑ Lumbar puncture
- ❑ Nail trephination
- ❑ Nail removal
- ❑ Nasal cautery
- ❑ Nasal packing
- ❑ Nasogastric intubation
- ❑ Ocular tonometry
- ❑ Oxygen therapy
- ❑ Paracentesis
- ❑ Pericardiocentesis
- ❑ Peritoneal lavage
- ❑ Radiographic studies and preliminary interpretation
- ❑ Respirators initiation: manual and mechanical
- ❑ Senkstaken-Blakemore tube placement
- ❑ Slit lamp examination
- ❑ Spinal immobilization
- ❑ Swan Ganz catheter insertion
- ❑ Thoracentesis
- ❑ Thoracostomy tube drainage
- ❑ Wound debridement/repair
- ❑ Wound dressing

Applicant's Name _____ Applicant's Initials _____

Release of Information

In order to evaluate my application for participation and/or my continued employment or engagement by Bayside Emergency Physicians, I hereby give permission to the Bayside Emergency Physicians to request from others, information regarding my professional credentials and qualifications and to contact my personal or professional references. This includes consent to contact Chief(s) of Clinical Departments of the hospital(s) in which I currently have staff privileges, professional certification boards, State Regulatory and Licensing Departments and professional liability insurance carriers. I understand the Bayside Emergency Physicians will use this information on its own behalf. I understand that individuals or corporations may be contacted to provide information relating to my prior employment, education, and character.

Furthermore, by signing below, I attest that the information provided in this application is true to the best of my knowledge. I further understand that falsifying any information is grounds for immediate dismissal.

Applicant's Printed Name _____

Applicant's Signature _____

Date _____