

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

IDENTI	EVINO INFORMATION
	FYING 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

Today's Data

	CATION				
EDUCATION Undergraduate College					
Degree					
Medical School					
Degree					
		A-100			
CONTINUING MI					
List in detail postgraduate courses you have completed which are related	to Emergency Medicin	ne and Trauma			
LIOTNOTO AND	O O E D TIELO A T	IONIO			
LICENSES AND Florida Medical License Number (attach a copy)	Exp. Date	IONS			
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 tentined? (attach a copy if yes) Are you a PALS Instructor? (attach a copy if yes)	Exp. Date				
Are you a PALS instructor? (attach a copy ii yes)	Exp. Date				
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(Please provide at least 10 years of professional					
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EMERGENCY DEPA Employer/Hospital Address City State Zip Phone Job Position Name of Medical Director/Supervisor Reason for Leaving	Prom Month/Yr. Base Hourly Starting	To Month/Year Rate/Salary Final			
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Employer/Hospital	Dates E	mployed	Work Performed
Address	From Month/Yr.	To Month/Year	
City State Zip			
Phone			
Job Position	Base Hourly	y Rate/Salary	
Name of Medical Director/Supervisor	Starting	Final	
Reason for Leaving			
Employer/Hospital	Dates E	Employed	Work Performed
Address	From Month/Yr.	To Month/Year	
City State Zip			
Phone			
Job Position	Base Hourly	y Rate/Salary	
Name of Medical Director/Supervisor	Starting	Final	
Reason for Leaving			
Employer/Hospital	Dates E	Employed	Work Performed
Address	From Month/Yr.	To Month/Year	
City State Zip			
Phone			
Job Position	Base Hourly	y Rate/Salary	1
Name of Medical Director/Supervisor	Starting	Final	1
Reason for Leaving			

NON-EMERGENCY	MEDICAL EXP	PERIENCE	
Employer/Hospital	Dates E	mployed	Work Performed
Address	From Month/Yr.	To Month/Year	
City State Zip	1		
Phone			
Job Position	Base Hourly	/ Rate/Salary	
Name of Supervisor	Starting	Final	
Reason for Leaving			
Employer/Hospital	Dates E	mployed	Work Performed
Employer/Hospital Address	Dates E	mployed To Month/Year	Work Performed
			Work Performed
Address			Work Performed
Address City State Zip	From Month/Yr.		Work Performed
Address City State Zip Phone	From Month/Yr.	To Month/Year	Work Performed

Applicant's Name	Applicant's Initials
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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	
Name, Title, and Position Phone Number	
Phone Number	City, State, Zip
Phone Number Email Address	City, State, Zip
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Phone Number Email Address Address How long have you known this person? How do you know this person? 4. Name, Title, and Position Phone Number Email Address Address	

Applicant's Name Applicant's Initials	
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ANSWER THE FOLLOWING QUESTIONS AND PROVIDE DETAILS FOR ANY "YES" ANSWERS

1. H	Has your Medical License in any jurisdiction ever been limited, suspended, or revoked?
2. I	Have your privileges at any location ever been suspended, diminished, or not renewed?
	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. l	Has any Professional Liability Insurance ever been denied, canceled, or renewal refused?
	Have you ever had involvement as a defendant in civil litigation involving assault/battery, intentional corts and/or any offense related to the practice of medicine?
	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. H	Have you ever been charged with violating COBRA/OBRA regulations?
)	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 erminated 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?
Applica	nt's Name Applicant's Initials

PLEASE CHECK THE PROCEDURES YOU HAVE PERFORMED

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 Disorders related to the immune systems Disorders caused by biological agents Urogenital disorders Cardiovascular disorders Disorders related to the immune systems Disorders related to the immune systems Disorders caused by biological agents Urogenital disorders Disorder primarily presenting in infancy and childhood Musculoskeletal disorders Nervous system disorders Psychobehavioral disorders Thoracic-respiratory disorders Laboratory studies and interpretation Laryngoscopy Disorder primarily presenting in infancy and childhood Laryngoscopy Disorder primarily presenting in infancy and childhood Light primarily presenting in infancy and childhood Li	Evalua	ation, stabilization, and initial treatment in the Eme	ergency C	are Center of:
□ Emergency cardiopulmonary and traumatic resuscitations □ Hormonal, metabolic, and nutritional disorders □ Abdominal and gastrointestinal disorders □ Disorders of the head and neck □ Cardiovascular disorders □ Disorder primarily presenting in infancy and childhood □ Disorders related to the immune systems □ Musculoskeletal disorders □ Disorders caused by biological agents □ Nervous system disorders □ Urogenital disorders □ Psychobehavioral disorders □ Psychobehavioral disorders □ Psychobehavioral disorders □ ACLS, ATLS Procedures □ Laboratory studies and interpretation □ Anesthesia; intravenous (upper extremity), local, and regional □ Laryngoscopy □ Anoscopy □ Nail trephination □ Arthrocentesis □ Nail trephination □ Bladder catheterization suprapubic and transurethral □ Nasal cautery □ Cannulation: artery and vein □ Nasogastric intubation □ Cardiac defibrillation □ Ocular tonometry □ Cardiac massage closed □ Oxygen therapy				
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□ Cardiac massage closed □ Oxygen therapy ⊂				
Development of the contract of				
5 1		Cardiac massage open		Paracentesis
□ Cardiac pacing: external, transthoracic, and □ Pericardiocentesis		•		
transvenous Peritoneal lavage				
□ Cardioversion □ Radiographic studies and preliminary				
□ Central venous access: jugular, peripheral, interpretation		, , , ,		•
subclavian, femoral, and cutdowns	_			
□ Conscious sedation mechanical			_	
□ Cutdowns □ Senkstaken-Blakemore tube placement	_			•
□ Cricothyrotomy □ Slit lamp examination				•
□ Culdocentesis □ Spinal immobilization	_		_	
□ Delivery of a newborn □ Swan Ganz catheter insertion			_	
□ EKG preliminary interpretation □ Thoracentesis			_	
□ Endotracheal intubation: oral and nasal □ Thoracostomy tube drainage			_	
□ Esophageal obturator airway insertion □ Wound debridement/repair		. •	_	•
□ Foreign body removal □ Wound dressing				vvoulia aressing
□ Fracture (simple)/dislocation reduction		, , ,		
□ Gastric lavage□ Incision-drainage				
□ Intracardiac injection				

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	