500 Dr. Martin Luther King Jr St N, Ste 304 St Petersburg, FL
33705 Phone (727) 210-5253 Fax (727) 290-4323

Physician 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	
Home Telephone 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	
Graduation Date	
Degree	
Medical School	
Graduation Date	
Degree	

POST GRADUATE EDUCATION

Hospital	
Type	
Dates	
Address of Hospital	
City, State, Zip	

RESIDENCY

Hospital	
Type	
Dates	
Address of Hospital	
City, State, Zip	
Did you complete your residency?	If no, give details on a separate sheet.
Hospital	
Type	
Dates	
Address of Hospital	
City, State, Zip	
Did you complete your residency?	If no, give details on a separate sheet.

CONTINUING MEDICAL EDUCATION

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

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			

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 _______

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			

OTHER PROFESSIONAL EXPERIENCE			
Employer	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	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	
1. Name, Title, and Position	
Phone Number	Email Address:
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:
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:
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:
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. Has your DEA Certificate ever been denied, suspended, or revoked?

8. 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?

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?

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

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 Bayside Emergency Physicians to request from others, information regarding my professional credentials and qualifications and 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 _____

FOR BEP USE ONLY

Name:

Position

Arrange Interview?

Remarks_____
_____

_____
_____

_____
_____

Hired?_____ Hourly rate of pay _____

Hire Date _____

Background Screen and Result

_____
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By _____