

Community Health Services

410 Birchard Avenue
Fremont, Ohio 43420

1-419-334-8943 (Phone)

1-419-334-8619 (FAX)

INFORMATION RELEASE FORM

I hereby authorize Community Health Services, Inc., 410 Birchard Avenue, Fremont, Ohio to investigate any and all information on this application. I consent to and authorize any other third party to provide such information; including, but not limited to evaluations, recommendations, work histories, to Community Health Services, Inc. I further release from any claim or liability all persons who furnish such information.

Signature and Date

Community Health Services
PROVIDER APPLICATION
410 Birchard Avenue
Fremont, Ohio 43420

Name _____ **M.D./D.O./D.D.S./D.M.D.**

Address _____

Phone (Home) _____ Phone (Work) _____

Present Position _____

When are you available to begin? _____

Name, Address and Phone Number of someone who will always know your forwarding address _____

PREMEDICAL EDUCATION

School of Graduation _____

Dates Attended _____ Degree _____

MEDICAL/DENTAL EDUCATION

School of Graduation _____

Dates Attended _____ Degree _____

INTERNSHIP

Hospital _____

City & State _____ Dates _____

Type of Internship _____

RESIDENCY

Hospital _____

City & State _____ Dates _____

Type of Internship _____

Board Eligible _____ Board Certified _____ Date _____

ADDITIONAL TRAINING AND/OR EXPERIENCE

(Please indicate complete data from end of training program to present, or attach separate letter of explanation)

BLS Certified _____ ACLS Certified _____ ATLS Certified _____

PROFESSIONAL PRACTICE HISTORY

Summarize professional practice associations for the past ten (10) years in chronological order beginning with your most recent practice. Include all private practices, clinics, HMOs, military experience, and any other practice associations in which you have been employed, had privileges or practiced on the full-time or part-time basis.

Current Practice _____
Address _____
Clinical Department _____
Inclusive Dates _____
Reason for Termination _____

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Inclusive Dates _____
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LICENSURE (Please attach or forward a copy of your Ohio Medical/Dental License and DEA certificate).

Flex Exam _____ National Boards _____ ECFMG _____

State _____ License No. _____ Exp. Date _____

State _____ License No. _____ Exp. Date _____

State _____ License No. _____ Exp. Date _____

Federal DEA No. _____ Exp. Date _____

REFERENCES: Please provide the names of three (3) professional references from training programs and/or current associates that we may contact:

Name _____ Title _____

Address _____

Phone _____ Dates of association _____

His/her position at time of your association _____

Name _____ Title _____

Address _____

Phone _____ Dates of association _____

His/her position at time of your association _____

Name _____ Title _____

Address _____

Phone _____ Dates of association _____

His/her position at time of your association _____

PROFESSIONAL LIABILITY

Please circle Yes or No. Explain "Yes" responses below.

- 1. Yes No Has membership in any professional association or society ever been revoked or refused?
- 2. Yes No Has any hospital suspended, restricted, or refused your staff privileges?
- 3. Yes No Have you ever voluntarily surrendered or had a state license to practice medicine refused, suspended, or revoked?
- 4. Yes No Have you ever voluntarily surrendered or had a narcotics license refused, suspended, or revoked?
- 5. Yes No Have you ever been treated for alcoholism, narcotic addiction, or mental illness?
- 6. Yes No Have you ever been convicted of a felony?
- 7. Yes No Have you ever suffered from, or been treated for, any chronic illness or physical defect?
- 8. Yes No Have you ever had any professional liability insurance refused, cancelled, or non-renewed?
- 9. Yes No Have you ever had a grievance filed against you with your County or State Medical Society?
- 10. Yes No Have you ever been named in a malpractice claim or lawsuit, either pending or closed?

Explanations:

I certify that the information in this application is true and correct to the best of my knowledge. I further understand that intentional falsification herein will subject me to removal from, and consideration of, the position or dismissal subsequent to employment.

Signature

Date

NOTICE: Please attach your release statement, medical license, DEA certificate, and board certification to this application.