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
AUTHORIZATION FOR THE RELEASE OF INFORMATION AND PROFESSIONAL REFERENCES

Professional References:

Please provide the names of three (3) professional references. If you are still in a residency program, or will soon complete a residency program, give the name of the Director of your residency program and the name of the Department Chair.

Avoid using professional partners or associates. Include those with whom you have had direct clinical involvement such as preceptors. Include at least one person with administrative responsibilities who has knowledge of your interaction with others and your compliance with facility rules and regulations.

These persons should forward letters of reference to the Medical Director at the address above as soon as possible. Thank you.

A. Name: ______________________ Title: ______________________

Address: ____

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Phone: (____) ________________ Dates of Association: ________________

His/her position at the time of your association:______________________

B. Name: ______________________ Title: ______________________

Address: ____

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Phone: (____) ________________ Dates of Association: ________________

His/her position at the time of your association:______________________

C. Name: ______________________ Title: ______________________

Address: ____

____

Phone: (____) ________________ Dates of Association: ________________

His/her position at the time of your association:__________

State Medical License(s):

State:________________ License No. ___________ Expiration Date:________
Received by (Check one) Reciprocity: ___________ Examination: __________

State:________________ License No. ___________ Expiration Date:________
Received by (Check one) Reciprocity: ___________ Examination: __________

State:________________ License No. ___________ Expiration Date:________
Received by (Check one) Reciprocity: ___________ Examination: __________

If you did not have a license for any state in which you were a resident or in which you performed clinical services, please explain. ____________________________________

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DEA Number:

DEA No.: ____________________________ Expiration Date: _________________

If you do not have a DEA number, please explain why: __________________________

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PERSONAL DATA

Driver's License(s): List driver's license(s) held in each state for the past five (5) years:

State: ________________ Number: _______________ Expiration: ____________

State: ________________ Number: _______________ Expiration: ____________

Social Security Number: __________________

PREVIOUS PLACES OF RESIDENCE:

Please list all previous places of residence for the past 10 years. Use additional sheets if necessary.

Street ____ Apt. #:__________

City: ______________________ State: ____________ Zip Code: ________

Length of residence: ___________

Street ____ Apt. #:__________

City: ______________________ State: ____________ Zip Code: ________

Length of residence: ___________

Street ____ Apt. #:__________

City: ______________________ State: ____________ Zip Code: ________

Length of residence: ___________

Street ____ Apt. #:__________

City: ______________________ State: ____________ Zip Code: ________

Length of residence: ___________

Street ____ Apt. #:__________

City: ______________________ State: ____________ Zip Code: ________

Length of residence: ___________

Street ____ Apt. #:__________

City: ______________________ State: ____________ Zip Code: ________

Length of residence: ___

III. EDUCATIONAL DATA

G. Teaching Appointments

Name/Address ____

____

Types of Appointment ____

Name of Department Chairperson: ______________________________

H. Post-Graduate and Continuing Education courses (in past three years)

Institution Name/Address ______________________________________

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Course Title: ____________________________ Dates: From _____ To _____

Institution Name/Address ______________________________________

____

Course Title: ____________________________ Dates: From _____ To _____

Institution Name/Address ______________________________________

____

Course Title: ____________________________ Dates: From _____ To _____

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IV. PROFESSIONAL PRACTICE HISTORY

A. Practice Associations

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

Specify clinical departments in which you practiced and the nature and extent of your practice, for example: "family practice department, full-time staff" or "pediatric department consultant, occasional."

State the reason(s) for termination of the practice association. Use a separate sheet if additional space is needed.

Current practice: ____

Address: ____

Clinical Dept.: ________________________ Inclusive Dates :____________________

Reasons for termination:

IV. PROFESSIONAL PRACTICE HISTORY (continued)

Practice: ____________________

Address: ____________________

Clinical Dept.: ____________________ Inclusive Dates :____________________

Reasons for termination: ____________________

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Practice: ____________________

Address: ____________________

Clinical Dept.: ____________________ Inclusive Dates :____________________

Reasons for termination: ____________________

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B. Hospital Affiliations

Summarize hospital affiliations for the past ten (10) years in chronological order beginning with the most recent affiliation. List all present and previous hospitals with which you have had association, employment, privileges, or practice. Include military experience. Specify clinical departments in which you practiced, and describe the nature and extent of your practice.

Use a separate sheet if additional space is needed. Provide, if possible, a copy of your privileges as defined with your present or most recent affiliation.

Hospital: ____________________
Address: ____________________
Clinical Department: ____________________
Inclusive Dates: ____________________
Reason(s) for Termination: ____________________
____

Hospital: ____________________
Address: ____________________
Clinical Department: ____________________
Inclusive Dates: ____________________
Reason(s) for Termination: ____________________
____

Hospital: ____________________
Address: ____________________
Clinical Department: ____________________
Inclusive Dates: ____________________
Reason(s) for Termination: ____

I certify that the information given in this application is true and correct to the best of my knowledge. I further understand that falsification, omission, or misrepresentation herein will result in my removal from consideration for the position or dismissal subsequent to Employment.

I hereby authorize previous employers, professional references, medical boards, certification boards, professional organizations, hospitals, malpractice carriers, and any other sources which have knowledge of my professional practice experience, training, or education to furnish any information concerning my personal character, habits, employment records, malpractice claims experience, or practice history.

I understand that an investigative consumer report may be made to confirm details of my background which are pertinent to the position for which I am being considered. You may conduct such investigations as may be necessary. I hereby release all persons from liability or damages incurred as a result of inquiry and/or furnishing this information.

Signature ______________________________ Date: