# *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, HMO's, 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 _____

Current Practice _____

Address _____

Clinical Department _____

Inclusive Dates _____

Reason for Termination _____

Current Practice _____

Address _____

Clinical Department _____

Inclusive Dates _____

Reason for Termination _____

Current Practice _____

Address _____

Clinical Department _____

Inclusive Dates _____

Reason for Termination _____

**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.

I attest that I have no physical or emotional problems that would inhibit my ability to perform any duties with regards to the privileges to be requested.

_____ _____

Signature Date

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

In order to perform a criminal background check as well as a check of the National Practitioner's Database, your Social Security Number and Date of Birth are required. Please submit both along with this application.