

# DENTIST APPLICATION

ALL QUALIFIED APPLICANTS RECEIVE CONSIDERATION WITHOUT REGARD TO RACE,  
COLOR, RELIGION, SEX, AGE, NATIONAL ORIGIN, DISABILITY, MARITAL STATUS,  
VETERAN STATUS OR ANY OTHER LEGALLY PROTECTED STATUS.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Home Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_

Social Security Number/EIN \_\_\_\_\_

Place of birth (city, state, country) \_\_\_\_\_ US Citizen \_\_\_ Yes \_\_\_ No

## LIST ALL STATES IN WHICH YOU HAVE BEEN OR ARE LICENSED

State \_\_\_\_\_ Lic # \_\_\_\_\_ Date issued \_\_\_\_\_ Expiration \_\_\_\_\_

State \_\_\_\_\_ Lic # \_\_\_\_\_ Date issued \_\_\_\_\_ Expiration \_\_\_\_\_

State \_\_\_\_\_ Lic # \_\_\_\_\_ Date issued \_\_\_\_\_ Expiration \_\_\_\_\_

State \_\_\_\_\_ Lic # \_\_\_\_\_ Date issued \_\_\_\_\_ Expiration \_\_\_\_\_

State \_\_\_\_\_ Lic # \_\_\_\_\_ Date issued \_\_\_\_\_ Expiration \_\_\_\_\_

## PROFESSIONAL REFERENCES

### WORK REFERENCES CORRESPONDING TO YOUR WORK HISTORY ON CV (SUPERIORS ONLY)

Name \_\_\_\_\_ Company \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Company \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Company \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Company \_\_\_\_\_ Phone \_\_\_\_\_

### PEERS WITH WHOM YOU'VE HAD CLINICAL CONTACT DURING THE PAST 12 MONTHS

Name \_\_\_\_\_ Company \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Company \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Company \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Company \_\_\_\_\_ Phone \_\_\_\_\_

**PREVIOUS CONTACT**

In order to eliminate duplication of effort and time wasted, please list the names of organizations that you have had contact with in the last year.

**CORRECTIONAL CARE ORGANIZATIONS**

Organization Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Organization Name \_\_\_\_\_

**CITY/STATE/FEDERAL ORGANIZATIONS**

Organization Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Organization Name \_\_\_\_\_

**OTHER ORGANIZATIONS**

Organization Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Organization Name \_\_\_\_\_

**Disclosure Questions - Please provide an explanation for any question answered “Yes” on a separate piece of paper.**

**Licensure**

- 1) Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board? \_\_\_\_\_ Yes \_\_\_\_\_ No
- 2) Have you ever received a reprimand or been fined by any state licensing board? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Hospital Privileges and Other Affiliations**

- 3) Have your clinical privileges or Medical Staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? \_\_\_\_\_ Yes \_\_\_\_\_ No
- 4) Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? \_\_\_\_\_ Yes \_\_\_\_\_ No
- 5) Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Education, Training and Board Certification**

- 6) Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign? \_\_\_\_\_ Yes \_\_\_\_\_ No
- 7) Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? \_\_\_\_\_ Yes \_\_\_\_\_ No
- 8) Have any of your board certifications or eligibility ever been revoked? \_\_\_\_\_ Yes \_\_\_\_\_ No
- 9) Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? \_\_\_\_\_ Yes \_\_\_\_\_ No

**DEA or State Controlled Substance**

- 10) Have your Federal DEA and/or STATE Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Medicare, Medicaid or other Governmental Program Participation**

- 11) Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Other Sanctions or Investigations**

- 12) Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program? \_\_\_\_\_ Yes \_\_\_\_\_ No
- 13) To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? \_\_\_\_\_ Yes \_\_\_\_\_ No

14) Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? \_\_\_\_\_ Yes \_\_\_\_\_ No

15) Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Malpractice Claims History**

16) Have you had any malpractice actions (pending, settled, arbitrated, mediated or litigated)? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Criminal**

17) Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony? \_\_\_\_\_ Yes \_\_\_\_\_ No

18) Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony, involving an act of violence, child abuse or a sexual offense? \_\_\_\_\_ Yes \_\_\_\_\_ No

19) Have you been court-martialed for actions related to your duties as a medical professional? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Ability to Perform**

20) Are you currently abusing alcohol, using any illegal drugs, or failing to take legally prescribed drugs in the manner prescribed? \_\_\_\_\_ Yes \_\_\_\_\_ No

21) Have you abused alcohol, used illegal drugs, or failed to take legally prescribed drugs in the manner prescribed in the past? If yes what drugs, and how recently have you used these illegal drugs? \_\_\_\_\_ Yes \_\_\_\_\_ No

22) Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? \_\_\_\_\_ Yes \_\_\_\_\_ No

23) Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients? \_\_\_\_\_ Yes \_\_\_\_\_ No

24) Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Disclosure Questions - Please provide an explanation for any question answered “Yes” on a separate piece of paper.**

## STANDARD AUTHORIZATION, ATTESTATION AND RELEASE

I understand and agree that, as part of the credentialing application process for consideration of placement as a locum tenens or permanent direct hire employee (hereinafter, referred to as "Participation") at, with or through:

Camden Healthcare Staffing  
Camden Healthcare Government Staffing  
Camden Healthcare Community Staffing  
AJ Riggins Health Search

(HEREINAFTER, INDIVIDUALLY REFERRED TO AS THE "ENTITY")

and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. In consideration of my Participation the information obtained relating to the application process will be shared with clients of the Entity at which I am being considered.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me a position or contract, of any type, with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

### *Authorization of Investigation Concerning Application for Participation.*

I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

### *Authorization of Third-Party Sources to Release Information Concerning Application for Participation.*

I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

### *Authorization of Release and Exchange of Disciplinary Information.*

I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Clients at which I am being considered, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: (I) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context;

or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

*Release from Liability.*

I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree that any Entity, any Agent(s), or any other party involved in the credentialing/application process is entitled to absolute immunity from suit. I agree not to sue any party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted in writing, and must be dated and signed by me. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NAME (PLEASE PRINT OR TYPE) \_\_\_\_\_



## INDEPENDENT CONTRACTOR DECLARATION

The undersigned service provider (the "Provider") declares, acknowledges and agrees that he/she is an independent contractor and is not an employee of Camden Healthcare Staffing, LLC or any of its affiliates.

1. I am a trained medical or dental practitioner engaged in the practice of medicine or dentistry.
2. I am solely responsible for my professional actions in providing dentistry services to patients at the contracted healthcare facilities or elsewhere.
3. Camden Healthcare Staffing, LLC does not have the right to direct or control the manner in which I practice my profession.
4. I independently determine the assignments I am willing to accept and the rate at which I will be paid for each assignment. I cannot be directed by Camden Healthcare Staffing, LLC to accept assignments.
5. Camden Healthcare Staffing, LLC does not direct my professional services in any manner, including the time, place, type of professional service, working conditions, quality of the professional service, my right to utilize or hire assistants, or the prices charged for the services I render.
6. I have the right to terminate my relationship with Camden Healthcare Staffing, LLC at any time, and I may terminate an assignment with or without cause by giving the agreed written notice.
7. To my knowledge, Camden Healthcare Staffing, LLC has no relationship with the healthcare facilities with whom I accept assignments other than that of a placement agency, and I understand that Camden Healthcare Staffing, LLC is not licensed to nor is it engaged in the practice of medicine or dentistry.
8. I am not employed by Camden Healthcare Staffing, LLC. As an independent contractor, I agree that I am responsible for and will pay all federal, state and local income or self-employment taxes due on payments received as a result of this assignment, and I am **NOT** entitled to claim unemployment benefits or workers compensation benefits against Camden Healthcare Staffing, LLC.
9. To the extent I receive payments from Camden Healthcare Staffing, LLC in relation to an assignment, such payments are made by Camden Healthcare Staffing, LLC on behalf of the Client.

This Declaration is a true and correct statement of the facts set forth herein.

This Declaration is executed effective as of \_\_\_\_\_, 2009.

MEDICAL OR DENTAL / PROVIDER

CAMDEN HEALTHCARE STAFFING, LLC

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Print Name)



## Date of Birth Form

I understand it is necessary for me to disclose my date of birth in order for Camden Healthcare Staffing's Assurance Department to verify my credentials.

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Date of Birth

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Provider's Signature

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Provider's printed name

Upon receipt, this document will be separated from the application packet, placed in your file, and will not be considered when making assignment decisions.

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