TTG Locum Tenens

884 Woods Mill Road, St. 101, St. Louis, MO 63011
636-891-9794 or 800-969-7952
WWW.Toberson.com/TTG Locum Tenens

This form can be completed online or printed. Upon completion please save and attach a copy to an email to info@toberson.com or print and fax to 636-891-9784.

## Personal General Profile

Last Name: First Name: MI:

Home Address: City: State: Zip:

Home Phone: Cell Phone: Email:

Office Address: City: State: Zip:

Citizenship: Date of Birth: Social Security #:

Alien Registration #: ECFMG: Date Issued:

## Practice Preferences (Check all that apply)

☐ Internal Medicine ☐ Family Practice ☐ Occupational Medicine ☐ Urgent Care

☐ Emergency Medicine ☐ Hospitalist ☐ Critical Care ☐ Women's Health

☐ Other Specialty

Willing to Travel ____ Yes ____ No Maximum Distance or Drive Time:

## Education

College/University Location: Phone:

Degree: Graduation Date: Honors:

## Graduate/Medical Degree

College/University Location: Phone:

Degree: Graduation Date: Honors:

## Internship

Location: Phone:

Type: Dates:

## Residency/Preceptorships, Fellowships

Location: Phone:

Type: Dates:

Location: Phone:

Type: Dates:

Location: Phone:

Type: Dates:

Location: Phone:

Type: Dates:

| **Licensing** (List all medical licenses ever held)<br><br>State: License #: | Date Issued | Date Expires |
|---|---|---|
| Controlled Substance Certificate#: | | |
| State: License #: | | |
| Controlled Substance Certificate#: | | |
| State: License #: | | |
| Controlled Substance Certificate#: | | |
| State: License #: | | |
| Controlled Substance Certificate#: | | |
| Federal Narcotics Certificate #: | | |

NPI # Medicare# Medicaid # UPIN#

**Actions** (Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, Limited, placed on probation, not renewed, or relinquished? If "YES", attach explanation.)

| | | |
|---|---|---|
| Any State Medical License | ☐ Yes | ☐ No |
| Other professional registration or license(s) | ☐ Yes | ☐ No |
| Federal DEA or State Controlled Substance Certificate Registration | ☐ Yes | ☐ No |
| Academic appointment | ☐ Yes | ☐ No |
| Membership on any medical staff | ☐ Yes | ☐ No |
| Clinical privileges at any health care facility | ☐ Yes | ☐ No |
| Prerogatives/rights on any medical staff | ☐ Yes | ☐ No |
| Other institutional affiliation or status threat | ☐ Yes | ☐ No |
| Professional society membership or fellowship/board certification | ☐ Yes | ☐ No |
| Professional office privileges | ☐ Yes | ☐ No |
| Any Other type of professional sanction | ☐ Yes | ☐ No |
| Have you ever been charged or convicted of a felony, pleaded "no contest" or Have been placed on probation for any offense other than a traffic violation? | ☐ Yes | ☐ No |

**Certification**

Are you Board Certified? Name of Board: Certificate#:

Are you Board Eligible? Are you scheduled to sit for the exam? ☐ Yes ☐ No Date Schedule:

**Affiliations** List all present and previous affiliations beginning with the current. Attach a separate sheet if necessary.

| | | |
|---|---|---|
| **Facility/Employer**: | From: | To: |
| Mailing Address: | Email: | Phone: |
| **Facility/Employer:** | From: | To: |
| Mailing Address: | Email: | Phone: |
| **Facility/Employer:** | From: | To: |
| Mailing Address: | Email: | Phone: |
| **Facility/Employer**: | From: | To: |
| Mailing Address: | Email: | Phone: |

**Continuing Medical Education (CME)** Attach a sheet listing all CME activities you have participated in and have received Credit for in the past two years.

**Malpractice Insurance** Enclose certificate of current malpractice coverage.

| | | |
|---|---|---|
| Present Carrier: | Liability Limits: | Policy #: |
| Contact Information: | | |

| | | |
|---|---|---|
| Has there ever been an interruption in coverage? | ☐ Yes | ☐ No |
| During the past ten years, have there been, or are there currently pending, any malpractice claims, suits, settlements, or arbitration proceedings involving your professional practice? | ☐ Yes | ☐ No |
| Have you ever been denied professional liability insurance? | ☐ Yes | ☐ No |
| Have you ever been denied life, disability, medical, or hospital insurance coverage? | ☐ Yes | ☐ No |
| **Personal Health**<br>Are you aware of any current or past physical/mental health conditions that affect, or are likely to affect, your ability to perform professional duties as a health care provider? In responding, please take into consideration any condition for which narcotic analgesics are used, impaired vision/hearing, alcoholism, drug dependency, mental illness, etc. | ☐ Yes | ☐ No |
| Are you aware of any current or past physical/mental health conditions that affect, or are likely to affect your ability perform any medical procedures that would be required of you as a health care provider? | ☐ Yes | ☐ No |

**If you have responded YES to any of the above questions, please attach a separate sheet with full details.**

| | |
|---|---|
| Signature: | Date: |