

Employment Application

GENERAL INSTRUCTIONS

Complete the application in full, print or type all responses. Attach additional sheets if there is insufficient space.

PERSONAL INFORMATION

Name in Full (Include all previous names if applicable)

Social Security Number

Date of Birth

Place of Birth (City, State, Country)

Office Address:

Phone

City

State

Zip

E-Mail

Fax

Home Address:

Home Phone

City

State

Zip

Cell Phone

E-Mail

Fax

Are you eligible to work in all locations within the United States? No Yes

If no, explain: _____

Have you been previously employed by Sanford (including St. Luke's, Fargo Clinic, MeritCare Sioux Valley, or Sanford affiliates)? No Yes

If so, provide dates of employment and job title _____

Applicants are considered for all positions without regard to race, color, religion, national origin, age, marital status, sex, disability, sexual orientation, status as Vietnam Era, or special disabled veteran in accordance with federal law. In addition, Sanford complies with applicable state and local laws prohibiting discrimination in employment in every jurisdiction in which it maintains facilities. Sanford also provides reasonable accommodation to individuals with disabilities in accordance with applicable laws.

EDUCATION

MEDICAL/PROFESSIONAL

	Degree Awarded	Dates Attended	Date Graduated
1. _____ University	_____	_____ to _____ (mo/yr) to (mo/yr)	_____ (mo/yr)
_____ Street Address			
_____ City/State/Zip			
2. _____ University	_____	_____ to _____ (mo/yr) to (mo/yr)	_____ (mo/yr)
_____ Street Address			
_____ City/State/Zip			

OTHER GRADUATE/PROFESSIONAL

	Major	Degree Awarded	Dates Attended	Date Graduated
1. _____ University	_____	_____	_____ to _____ (mo/yr) to (mo/yr)	_____ (mo/yr)
_____ Street Address				
_____ City/State/Zip				
2. _____ University	_____	_____	_____ to _____ (mo/yr) to (mo/yr)	_____ (mo/yr)
_____ Street Address				
_____ City/State/Zip				

POST GRADUATE TRAINING

Internship/Residencies/Fellowship/Preceptorships:

1. Type _____
Area/Specialty _____
Institution _____
Address _____

City/State/Zip _____

Dates _____ to _____
(Mo/Yr) (Mo/Yr)
Program Completed? Yes No
If no, explain _____
Program Director _____
Phone # _____
Fax # _____

2. Type _____
Area/Specialty _____
Institution _____
Address _____

City/State/Zip _____

Dates _____ to _____
(Mo/Yr) (Mo/Yr)
Program Completed? Yes No
If no, explain _____
Program Director _____
Phone # _____
Fax # _____

3. Type _____
Area/Specialty _____
Institution _____
Address _____

City/State/Zip _____

Dates _____ to _____
(Mo/Yr) (Mo/Yr)
Program Completed? Yes No
If no, explain _____
Program Director _____
Phone # _____
Fax # _____

4. Type _____
Area/Specialty _____
Institution _____
Address _____

City/State/Zip _____

Dates _____ to _____
(Mo/Yr) (Mo/Yr)
Program Completed? Yes No
If no, explain _____
Program Director _____
Phone # _____
Fax # _____

5. Type _____
Area/Specialty _____
Institution _____
Address _____

City/State/Zip _____

Dates _____ to _____
(Mo/Yr) (Mo/Yr)
Program Completed? Yes No
If no, explain _____
Program Director _____
Phone # _____
Fax # _____

LICENSURES/REGISTRATIONS

(List all, indicate any restrictions in last column and attach an explanation on a separate sheet.)

State/Country	Type	Number	Date Issued	Date Expires (Mo/Day/Yr)	Restricted <input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>

Controlled Substance Registration:

Federal: Number _____ State _____ Date Expires: _____
 (DEA) (Mo/Day/Yr)

Federal: Number _____ State _____ Date Expires: _____
 (DEA) (Mo/Day/Yr)

OTHER REQUIRED NUMBERS

National Practitioner Identifier (NPI)* _____ UPIN _____

* (Please attach a copy of your NPI notification letter from Medicare.)

ECFMG # _____ Date Issued _____
 (mo/day/yr)

BOARD CERTIFICATION STATUS

Specialty/Subspecialty Certification	Certifying Board Name	Date Certified	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____

*Exam test date: _____ Application made to Board: _____
 (Mo/Yr) (name of Board)

*This item means actively in the board examination process with a specified number of years remaining according to the board's requirements in which the process must be completed.

Have you ever failed a certification? Yes No

If yes, please provide details: _____

Please include the components of the exam already taken, including the sections passed or failed, the number of times the exam has been taken. _____

CHRONOLOGY OF PROFESSIONAL CAREER

(List all current and prior in chronological order, most recent first.)

Academic Appointments:

Name and Complete Mailing Address	Rank	Department	Dates on Staff
1. _____ Name	_____	_____	_____ to _____ (Mo/Yr) (Mo/Yr)
_____	_____	_____	_____
Street Address	Phone		Department Chair
_____	_____		
City/State/Zip	Fax		
2. _____ Name	_____	_____	_____ to _____ (Mo/Yr) (Mo/Yr)
_____	_____	_____	_____
Street Address	Phone		Department Chair
_____	_____		
City/State/Zip	Fax		

Hospital Affiliations: (List all current and prior in chronological order, most recent first.)

Name and Complete Mailing Address	Department Service	Staff Category	Dates on Staff
1. _____ Name	_____	_____	_____ to _____ (Mo/Yr) (Mo/Yr)
_____	_____	_____	_____
Street Address	Phone		Department Chair
_____	_____		
City/State/Zip	Fax		
2. _____ Name	_____	_____	_____ to _____ (Mo/Yr) (Mo/Yr)
_____	_____	_____	_____
Street Address	Phone		Department Chair
_____	_____		
City/State/Zip	Fax		
3. _____ Name	_____	_____	_____ to _____ (Mo/Yr) (Mo/Yr)
_____	_____	_____	_____
Street Address	Phone		Department Chair
_____	_____		
City/State/Zip	Fax		
4. _____ Name	_____	_____	_____ to _____ (Mo/Yr) (Mo/Yr)
_____	_____	_____	_____
Street Address	Phone		Department Chair
_____	_____		
City/State/Zip	Fax		

Hospital Affiliations Continued: (If additional room is needed, please make additional copies of this page.)

Name and Complete Mailing Address	Department Service	Staff Category	Dates on Staff
5. _____ Name	_____	_____	_____ to _____ (Mo/Yr) to (Mo/Yr)
_____	_____	_____	_____
Street Address	Phone	_____	Department Chair
_____	_____	_____	_____
City/State/Zip	Fax	_____	_____
6. _____ Name	_____	_____	_____ to _____ (Mo/Yr) to (Mo/Yr)
_____	_____	_____	_____
Street Address	Phone	_____	Department Chair
_____	_____	_____	_____
City/State/Zip	Fax	_____	_____
7. _____ Name	_____	_____	_____ to _____ (Mo/Yr) to (Mo/Yr)
_____	_____	_____	_____
Street Address	Phone	_____	Department Chair
_____	_____	_____	_____
City/State/Zip	Fax	_____	_____
8. _____ Name	_____	_____	_____ to _____ (Mo/Yr) to (Mo/Yr)
_____	_____	_____	_____
Street Address	Phone	_____	Department Chair
_____	_____	_____	_____
City/State/Zip	Fax	_____	_____
9. _____ Name	_____	_____	_____ to _____ (Mo/Yr) to (Mo/Yr)
_____	_____	_____	_____
Street Address	Phone	_____	Department Chair
_____	_____	_____	_____
City/State/Zip	Fax	_____	_____
10. _____ Name	_____	_____	_____ to _____ (Mo/Yr) to (Mo/Yr)
_____	_____	_____	_____
Street Address	Phone	_____	Department Chair
_____	_____	_____	_____
City/State/Zip	Fax	_____	_____
11. _____ Name	_____	_____	_____ to _____ (Mo/Yr) to (Mo/Yr)
_____	_____	_____	_____
Street Address	Phone	_____	Department Chair
_____	_____	_____	_____
City/State/Zip	Fax	_____	_____

Employment: List all current and prior (if additional room is needed please make additional copies of this page).

1. _____
Name

Street Address

City/State/Zip

Phone

Fax

_____ to _____
Dates (Mo/Yr) (Mo/Yr)

Nature of Practice

Reason for Leaving

2. _____
Name

Street Address

City/State/Zip

Phone

Fax

_____ to _____
Dates (Mo/Yr) (Mo/Yr)

Nature of Practice

Reason for Leaving

3. _____
Name

Street Address

City/State/Zip

Phone

Fax

_____ to _____
Dates (Mo/Yr) (Mo/Yr)

Nature of Practice

Reason for Leaving

4. _____
Name

Street Address

City/State/Zip

Phone

Fax

_____ to _____
Dates (Mo/Yr) (Mo/Yr)

Nature of Practice

Reason for Leaving

Other Practice History: Please list any other activities/affiliations not previously recorded on this application. ***There should be no unexplained gaps from the date of completion of graduate school to the present. Attach additional pages as needed.***

	Activity/Affiliation (Ex. Military Service, Personal Leave, etc.)	Dates (Mo/Yr) to (Mo/Yr)
1.	_____	_____
2.	_____	_____
3.	_____	_____

PROFESSIONAL LIABILITY INSURANCE

If you are not going to be covered by Sanford’s malpractice insurance, please submit a copy of the face sheet of your policy showing policy limits, any coverage limitations, and expiration date.

Present Carrier: _____
Name Address

Agent: _____
Name Address Telephone No.

Expiration Date: _____
(Mo/Day/Yr)

1. Have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice? Yes No

2. Have you ever been denied professional liability insurance, has your coverage ever been cancelled, or have you ever been levied a surcharge on your own claims experience? If yes, please provide details on a separate sheet. Yes No

If question 1 is answered “yes”, please complete the attached malpractice sheet for each situation:

DISCIPLINARY 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 voluntarily relinquished, or have you ever withdrawn or failed to proceed with an application for any of the following? If yes, please provide a full explanation on a separate sheet.

- | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| Professional license in any state | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| DEA/state controlled substance registrations | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Academic appointment | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Internship/Residency/Fellowship | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Membership on any hospital medical staff | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Clinical privileges | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Prerogatives/rights on any medical staff | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Other institutional affiliation or status or authorization to provide services | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Professional society membership or fellowship/Board certification | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any other type of professional sanction | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Have you ever resigned employment with any employer in lieu of impending investigation, complaint, disciplinary action, or termination? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Have you ever been terminated or involuntarily separated from employment? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is there any reason that performing the essential functions of the clinical privileges you have requested would create a direct threat to the health or safety of patients, yourself, or others that could not be eliminated or reduced by reasonable accommodations? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is there any reason why you would be unable to perform the essential functions of the clinical privileges you have requested? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Do you have any conditions, restrictions, or limitations including but not limited to supervision requirements, relating to your access or administration of controlled substances and/or prescription narcotics to patients while performing job duties? Yes No

Have you been convicted of, plead guilty to, or pleaded no contest to any criminal charges (other than motor vehicle speeding violations) brought against you? (If yes, please provide a full explanation on a separate sheet, including dates, initial charges, and resolution of charges on a separate sheet.) (Criminal convictions will not automatically bar consideration for employment and will only be considered as they relate to specific job requirements.) Yes No

Have you been sanctioned by a Professional Standards Review Organization, Peer Review Organization, or similar agency? (If yes, please provide a full explanation on a separate sheet.) Yes No

Have you ever been sanctioned by, terminated from, excluded from, or refused/denied participation in any state, federal, or private health benefit or health insurance program, plan, policy or payer, including, but not limited to the Medicare and Medicaid programs? (If yes, please provide a full explanation on a separate sheet, including any resolution of the issues.) Yes No

Are you currently under any sanction that precludes you from enrolling as a participating provider with the Medicare, Medicaid or any other federal or state benefit program? (If yes, please provide a full explanation on a separate sheet, including the nature and extent of any such sanction.) Yes No

Are you currently engaged in the illegal use of controlled substances, including use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a health care provider). "Currently" is not limited to the day of or even days preceding the completion of this application. Rather it means recently enough so that the illegal use may have an impact on your ability to practice. Yes No

REFERENCES

Name three medical or health care professionals who have personal knowledge of your current clinical abilities, ethical character, health status, and ability to work cooperatively with others and who will provide specific written comments on these matters upon request. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time and, at least one must be a colleague in your specialty. The individuals should not be related to you. **These references should be in addition to program directors if residency/fellowship was completed within the past five years.**

Name

Telephone

Address

E-Mail

City/State/Zip

Fax

Name

Telephone

Address

E-Mail

City/State/Zip

Fax

Name

Telephone

Address

E-Mail

City/State/Zip

Fax

Please attach your current CV to this application.

AUTHORIZATION AND NOTICE

Applicant represents to Sanford Medical Center and Sanford Clinic (Collectively "Sanford"), that all information submitted by me in this application is true and complete to my best knowledge and belief. A photo static copy of this original statement constitutes my written authorization and request to release any and all documentation relevant to this application. Said photo static copy shall have the same force and effect as the signed original. Misstatements in or omission from this application constitute cause for denial of appointment/ reappointment or cause for immediate termination from employment. I understand that I am expected to fully and accurately respond to all of the questions in the application. Any incomplete information, omission, or false statement relating to any responses to the questions set forth in the applicant may result in denial of privileges, denial of employment, or revocation of privileges and/or termination of employment.

As an applicant, I understand termination from employment automatically terminates all clinical privileges from Sanford Clinic.

As an applicant, I have the burden of producing adequate information for proper evaluation of my application to include evaluation of my health status, professional competence, character, ethics, the ability to work cooperatively with others, and other qualifications, and the burden of resolving any doubts about such qualifications. I agree to appear for interviews concerning my application or reapplication for staff privileges.

I agree to inform Sanford's Office of Professional Practice of any change or proposed changes in the status of my professional license or permit to practice, state or federal controlled substances registrations, professional liability insurance coverage, and membership/ employment/faculty status or clinical privileges in other institutions/facilities/organizations, or of the existence of any disciplinary proceeding, as defined in the application and on the status of current or initiation of new malpractice claims.

If I am applying to Sanford Medical Center, I agree to be bound by and have been given access to Sanford Medical Center's Medical/ Professional Bylaws, Staff Rules and Regulations, policies and procedures as Sanford may from time to time enact. If I am applying to Sanford Clinic, I agree to be bound by and have been given access to Sanford Clinic's policies and procedures as the Clinic may from time to time enact. Further, I acknowledge that I am familiar with the principles of medical ethics of the American Medical/Professional Associations and the principles and standards of the Joint Commission, and agree to adhere to said principles and standards.

I acknowledge in accepting Sanford Medical Center medical/professional staff appointment and/or Sanford Clinic employment that I have a responsibility to participate in patient care and administrative responsibilities as reasonably called upon by Sanford.

I acknowledge that provisions of said Sanford Medical Center Medical Staff Bylaws and/or Sanford Clinic policies relating to confidentiality and release from liability are express conditions to my application for, and acceptance to the Sanford Medical Center Medical Staff and/or Sanford Clinic employment.

I pledge to maintain an ethical practice, to provide continuous care for my patients, and to refrain from delegating the responsibility for any aspect of the care of my patients to any practitioner not qualified to under that responsibility.

I authorize Sanford Clinic, Sanford Medical Center, or any affiliate of Sanford Health (collectively "Sanford") to obtain from any hospital, clinic, educational institution, professional organization, governmental agency, third party payer, professional liability carrier, or any other individual or entity with whom I have been or associated, all information pertaining to my education, professional background and training, competence, character, ethical qualifications, malpractice claims history, and malpractice insurance coverage including without limitation, all educational transcripts, records, and reports; all professional liability claims histories and reports; records pertaining to professional discipline; records of any medical society or professional review organization including records arising out of any charges against me; hospital credentialing records, including records relating to any claim for limitation, denial, or suspension of my hospital privileges; all employment files, including all reports, evaluations, and records of disciplinary proceedings; and records relating to credentialing by any third party payer or governmental agency, including but not limited to information from the National Practitioner's Data Bank. Any entity that has information pertinent to the foregoing is authorized to discuss the information with agents or representatives of Sanford, and to provide them with access to and copies of any records pertaining to such information. I recognize that some of the information which I have authorized to be released to Sanford may be confidential under applicable laws, bylaws, policies, or agreements. I authorize the release of such information to Sanford, notwithstanding its confidential nature and provide absolute immunity to Sanford and any entity responding to this request.

If I am hired by Sanford, I understand that Sanford may occasionally be requested to respond to requests for information regarding my employment with Sanford, including providing information to medical boards and authorities regarding my activities. I hereby authorize and consent to the release of such information by Sanford and its staff for any reason, on written request, provided such request is accompanied by a written authorization signed by me, including information that might otherwise be considered to be peer review activities. I hereby release from liability and provide absolute immunity to Sanford, its staff and representatives for so doing, subject to my right to respond to any information so provided.

I hereby release from liability and provide absolute immunity all representatives of Sanford, its medical staff, employees, agents, and their authorized representatives for their acts performed in connection with evaluating my application, my credentials, current competency and my qualifications; and I hereby release from any liability and provide absolute immunity to the Medical Center and any and all individuals and organizations who provide information to Sanford, its medical staff, or employees, agents, Office of Professional Practice, and their authorized representatives who may have information that may be material to this evaluation.

I acknowledge this authorization is effective until revoked by me in writing to the Office of Professional Practice.

Signature of Applicant

(Date)

(Print Name)

SANFORD MEDICAL CENTER AND SANFORD CLINIC

1. Recommendation of the Managing Physician Partner:

Appointment:

Recommended Not Recommended

Category

- Active
- Associate
- Adjunct
- Affiliate
- Ambulatory

Privileges

- Shall be the same as attached
- Shall change in scope of clinical privileges

Specify: _____

Managing Physician Partner

Date

2. Recommendation of the Executive Physician Partner:

Appointment as recommended by the Managing Physician Partner

Rejection of appointment by reason of: _____

Executive Physician Partner

Date

3. Recommendation of the Senior Vice President:

Appointment as recommended by the Executive Physician Partner

Rejection of reappointment by reason of: _____

Senior Vice President

Date

4. Recommendation of the Credentials Committee:

The Credentials Committee hereby recommends:

Appointment as recommended by the Department

Rejection of appointment by reason of: _____

Date

5. Board of Governors:

The Board of Governors takes the following course of action:

Appoints

Appointment with the following stipulation(s): _____

Defers appointment by reason of _____

Date

6. Recommendation of the Executive Committee:

The Executive Committee hereby recommends to the Board of Directors:

Appointment as recommended by the Credentials Committee

Rejection of appointment by reason of: _____

Date

7. Medical Center Board of Directors:

The Medical Center Board of Directors takes the following course of action:

Appoints

Appointment with the following stipulation(s): _____

Defers appointment by reason of _____

Date