Print Name: _____

CONTRACTOR INITIAL APPLICATION

Welcome to Jackson and Coker. Please complete and return the enclosed independent contractor application packet along with the copies of the documents listed below.

Please return all requested documents to:

Jackson & Coker
3000 Old Alabama Road
Suite 119-608
Alpharetta, GA 30022
800.272.2707 toll free
800.936.4562 fax

Attach current photo here.
Indicate date taken and sign in ink across the bottom of photo.

Note: Photo must be

1. Original
2. No larger than 3 by 4 inches
3. Taken within one year of application
4. Close-up view of self – not profile
5. Instant Polaroid photographs not acceptable

Your Signature Across the Bottom and Date

Checklist:

- ☐ **Photo**
- ☐ **CV**
- ☐ **Diploma**
- ☐ **Internship Certificate**
- ☐ **Residency Certificate**
- ☐ **Fellowship Certificate**
- ☐ **Board Certification (Certificate or Letter)**
- ☐ **Active and Inactive Medical Licenses**
- ☐ **ECFMG Certificate**
- ☐ **Federal DEA**
- ☐ **State Controlled Substances Certificates**
- ☐ **ACLS, BCLS, ATLS, PALS**
- ☐ **NPI Confirmation/Email**
- ☐ **Current Driver's License/Passport**
- ☐ **Malpractice Claims History Form**
- ☐ **Copy of Permanent Residency Card or VISA (non-US citizens)**

Thank you for allowing us the opportunity to work with you!

JACKSON & COKER

Print Name: _____

PERSONAL INFORMATION

Last Name First Name Middle			Degree	Social Security Number	
Specialty	Other Names Used			Maiden Name	Gender (m/f)
Home Address				Home Phone Number	
City State Zip code				Cell Phone Number	
Office Address				Office Phone Number	
City State Zip code				Office Fax Number	
US Citizen ☐ Yes ☐ No	Birthplace		Date of Birth	Email Address	
If not a US Citizen, are you authorized to work in the US? ☐ Yes ☐ No	If not a US Citizen, please provide VISA status		NPI #	Medicare #	
Fed Tax ID	Medicaid #				
Do you wish to contract with J&C as a corporate entity? ☐ Yes ☐ No			If yes, please provide name of entity		
Emergency Contact Name	Emergency Contact Phone		Emergency Contact Relationship		

EDUCATION AND TRAINING

Medical School	Degree			
City State	Dates (From mm/yy To mm/yy)	Program completed? ☐ Yes ☐ No		
Internship Facility Name	Specialty			
City State	Dates (From mm/yy To mm/yy)	Program completed? ☐ Yes ☐ No	In good standing with program? ☐ Yes ☐ No	
Residency Facility Name	Specialty			
City State	Dates (From mm/yy To mm/yy)	Program completed? ☐ Yes ☐ No	In good standing with program? ☐ Yes ☐ No	
Fellowship Facility Name	Specialty			
City State	Dates (From mm/yy To mm/yy)	Program completed? ☐ Yes ☐ No	In good standing with program? ☐ Yes ☐ No	
Additional Training	Specialty			
City State	Dates (From mm/yy To mm/yy)	Program completed? ☐ Yes ☐ No	In good standing with program? ☐ Yes ☐ No	

JACKSON & COKER

Print Name: _____

MILITARY SERVICE

Branch of Service	Dates of Service (From mm/yy To mm/yy)	Date of Discharge	Type of Discharge

BOARD CERTIFICATION/RECERTIFICATION

Are you currently board certified? ☐ Yes ☐ No List all current and past board certifications

Name of Issuing Board	Specialty	Date Certified (mm/yy):	Date Recertified (mm/yy):	Date Recertified (mm/yy):	Expiration Date (if any)(mm/yy):

Please answer the following questions. Attach explanation form(s) if necessary.

A.	Have you ever been examined by any specialty board, but failed to pass? If yes, please provide name of board(s) and date(s):	☐ Yes ☐ No
B.	If you are not currently certified, have you applied for the certification examination? If yes, please provide date you will sit for exam.	☐ Yes ☐ No

CERTIFICATIONS

BLS Certification: ☐ Yes ☐ No Expiration Date (mm/yy):	ACLS Certification: ☐ Yes ☐ No Expiration Date (mm/yy):	ATLS Certification: ☐ Yes ☐ No Expiration Date (mm/yy):	PALS Certification: ☐ Yes ☐ No Expiration Date (mm/yy):

DEA

Federal DEA Number:	DEA Expiration Date:

FOREIGN GRADUATES

Do you have a permanent ECFMG Certificate? ☐ Yes ☐ No	ECFMG Certificate #:	Did you do a Fifth Pathway? ☐ Yes ☐ No If so, where?

LICENSURE

Please enter the information in the table below for all states in which you have held a medical license.

State	License Number	License Status	Date License Granted (mm/dd/yy)	License Expiration Date (mm/dd/yy)	State Controlled Substance Permit Number
		Initial License ☐ ☐Active ☐Inactive			
		☐Active ☐Inactive			
		☐Active ☐Inactive			
		☐Active ☐Inactive			
		☐Active ☐Inactive			

☐ Additional licenses listed on attached sheet

Print Name: _____

REFERENCES

Please list four **physician** references that are able to comment upon your clinical and professional capabilities, **within the past year**.

Name	Specialty	Institution	Email
Phone #	Alternate Phone	Did this person have direct contact with you? ☐ Yes ☐ No	
Name	Specialty	Institution	Email
Phone #	Alternate Phone	Did this person have direct contact with you? ☐ Yes ☐ No	
Name	Specialty	Institution	Email
Phone #	Alternate Phone	Did this person have direct contact with you? ☐ Yes ☐ No	
Name	Specialty	Institution	Email
Phone #	Alternate Phone	Did this person have direct contact with you? ☐ Yes ☐ No	
Name	Specialty	Institution	Email
Phone #	Alternate Phone	Did this person have direct contact with you? ☐ Yes ☐ No	

WORK HISTORY & LOCUM TENENS EXPERIENCE

Please list all your practice locations and employment affiliations to cover at least the past ten years of clinical practice. ***Beginning and ending month and year are required for each listing.*** You may attach an additional sheet if all required work history information will not fit in this section.

From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
To Present ☐		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
To Present ☐		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
To Present ☐		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
To Present ☐		Address	City	State	Zip Code

Print Name: _____

GAP

Please provide explanation for gaps over 30 days within the last 10 years.
From (mm/yy) to (mm/yy).

MALPRACTICE CLAIMS HISTORY

1. Have you ever been denied professional liability insurance or denied renewal of an existing policy?
If the answer to the above question is "YES" please attach a brief explanation.
☐ Yes ☐ No

2. Have any malpractice claims, suits, settlements, or arbitration proceedings ever been made against you including any that have been dismissed?
☐ Yes ☐ No

3. Are you aware of any claims, suits, or settlements currently pending or of any intent to file a claim or suit?
☐ Yes ☐ No

If your answer to any of the above questions is "Yes", please provide the following information on each and provide a brief clinical summary of each case.

CLAIMS INFORMATION

Date of Incident: (mm/yy)

Condition treated:

Alleged negligence:

Current Status of Claim: (Pending, Dismissed, Defense Verdict, Withdrawn, Settled)

Date of closing: (mm/yy)

If settled, indicate total amount of settlement or award:

Amount paid on your behalf:

Please provide narrative description of the medical facts.

ADDITIONAL INFORMATION

As a Federal contract holder, J&C tabulates the following data to prepare statistics for required annual reporting (your responses are optional):

☐ Minority (a minority group member is an individual who is a U.S. citizen with at least 25 percent Asian-Indian, Asian-Pacific, Black, Hispanic, or Native American heritage.)
☐ Veteran
☐ Disabled Veteran

Print Name: _____

DISCIPLINARY ACTIONS OR OTHER

If your answer to any of the following questions is "Yes", please provide a full explanation and include any additional documentation if necessary.

Have any of the following ever been, or are currently in the process of being (voluntarily while under investigation or involuntarily, public or private) denied, revoked, suspended, reduced, limited, placed on probation, not renewed, surrendered, investigated, terminated, lost, withdrawn, restricted, reprimanded, disciplined, stipulated, fined, excluded, discharged, made subject to a consent order, or relinquished?

1. Medical License in any state? ☐ Yes ☐ No	6. Institutional affiliation / status? ☐ Yes ☐ No
2. DEA Registration (federal or state programs)? ☐ Yes ☐ No	7. Professional society membership or fellowship / Board certification? ☐ Yes ☐ No
3. Other Professional Registration / License? ☐ Yes ☐ No	8. Any professional sanction (e.g. government, administrative agency or other)? ☐ Yes ☐ No
4. Clinical Privileges? ☐ Yes ☐ No	9. Participation in any private, federal, or state health insurance program (e.g. Medicare, Medicaid, etc.)? ☐ Yes ☐ No
5. Membership / Rights on any medical staff? ☐ Yes ☐ No	

10. Are you currently using illegal drugs or legal drugs in an illegal manner?
☐ Yes ☐ No

11. Is there any reason that you are unable to perform the essential functions of the position for which you are applying safely and according to accepted standards of performance with or without reasonable accommodation? (If yes, explain on the attached form)
☐ Yes ☐ No

12. Do you currently have any physical or mental condition(s) that may affect your ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which you are submitting this Application? (Note: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current participation in aftercare programs for alcohol or drug dependency, medical limitation of activity, workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.)
☐ Yes ☐ No

13. Have you ever been indicted for, charged with, or convicted of, or are you currently under indictment or charged with any act committed in violation of any law or ordinance other than traffic offenses?
☐ Yes ☐ No

14. Are any criminal charges currently pending against you in any jurisdiction?
☐ Yes ☐ No

15. Have you ever been arrested for or charged with a crime involving children; sexual offense, including but not limited to sexual harassment; or a crime involving moral turpitude?
☐ Yes ☐ No

16. Is there any other issue which should be disclosed that may have an adverse impact on your ability to deliver effective clinical health care services?
☐ Yes ☐ No

17. Has any information pertaining to you ever been reported to the National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protections Data Bank (HIPDB)?
☐ Yes ☐ No

18. Has there been any change in your practice/specialty in the last 5 years?
☐ Yes ☐ No

Print Name: _____

INDEPENDENT CONTRACTOR STATEMENT

The undersigned service Contractor (the "Contractor") states, acknowledges and agrees that he/she is an independent contractor and is not an employee of Jackson & Coker Medical Group, LLC ("Jackson & Coker") or any of its affiliates, including but not limited to Jackson & Coker LocumTenens, LLC.

1. I am a trained healthcare Contractor engaged in the practice of healthcare.

2. I am solely responsible for my professional actions in providing services to patients at the contracted healthcare facilities or elsewhere.

3. Jackson & Coker 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 Jackson & Coker to accept assignments.

5. Jackson & Coker 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 am capable of performing the services required by the assignments I accept. I understand that Jackson & Coker does not control the working environment for the assignment and I will address any requests for assistance, accommodations or modifications necessary to perform the services directly with the healthcare facilities.

7. My contract with Jackson & Coker governs termination of my contractual relationship with Jackson & Coker and the termination of my participation in a particular assignment.

8. To my knowledge, Jackson & Coker has no relationship with the healthcare facilities with whom I accept assignments other than that of a contracted placement agency, and I understand that Jackson & Coker is not licensed to nor does engage in the practice of medicine.

9. I am not employed by Jackson & Coker. 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 Jackson & Coker.

10. To the extent I receive payments from Jackson & Coker in relation to this assignment, such payments are made by Jackson & Coker on behalf of the client for the services I have provided to the client.

This Declaration is a true and correct statement of the facts set forth herein.
This Declaration is executed as of (mm/dd/yy):

CONTRACTOR

_____
(Signature)

_____
(Print Name)

 JacksonCoker.com | 3000 Old Alabama Road Suite 119-608 | Alpharetta, GA 30022 | phone 800.272.2707 | fax 800.936.4562

Print Name: _____

AUTHORIZATION, ATTESTATION AND RELEASE

I acknowledge that Jackson & Coker LocumTenens, LLC ("J&C") will provide (i) certain services in the furtherance of one or more applications to state medical boards or other designated bodies ("Boards") to secure for me a license to practice medicine in one or more states ("License Applications" and, together with any credentialing applications, the "Applications") and (ii) certain credentialing services from time to time on an on-going basis in connection with my candidacy for locum tenens or full-time placement with healthcare clients (each a "Client"). "Information" includes, but is not limited to, otherwise privileged or confidential information concerning my professional qualifications, credentials, current licensure, education, training, clinical competence, professional references, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnoses and treatment, ethics, behavior, or any other matter having a bearing on my qualifications for a license to practice medicine or for sourcing and screening with J&C and credentialing with the Clients, including information about disciplinary actions or other credentials or confidential information (whether it has such a bearing may be presumed by such third parties solely by receipt of a request of Information from an Agent).

I further acknowledge and understand that my cooperation in providing and assisting J&C in obtaining my Information and my consent to the release of Information does not guarantee that any state will grant me a license to practice medicine or that a Client will grant me clinical privileges or contract with me as a provider of healthcare services. I understand that my Independent Contractor Application is not an application for employment and that acceptance of my application will not in itself result in my employment.

Authorization of Investigation Concerning Application
I authorize J&C and its Clients, and their respective employees, affiliated entities, representatives, and agents (together and individually the "Agents"), to collect, hold, and investigate both oral and written statements, records, and documents containing my Information, concerning or to be included in any of my Applications. I agree to allow the Agents to inspect and copy all records and documents relating to any Application and to disclose any such Information to a Client, any Board and other appropriate third parties and to share any such Information among themselves in connection with their investigations.

Authorization of Third-Party Sources to Release Information
I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, current and 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, promptly upon an Agent's request to release Information to the Agent(s). I authorize my current and past professional liability carrier(s) to release to Agents 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.

Release from Liability
I release from all liability and hold harmless the Agents, any entity responding to a request for Information by an Agent as authorized hereunder and any other third party, and their respective owners, managers, directors, officers, employees, agents and representatives, for their acts performed in good faith and without malice, unless such acts are due to the gross negligence or willful misconduct of such Agent or other third party, in connection with the gathering, holding, use, sharing and interpretation of, and reliance upon, Information. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for credentialing activities.

Attestation
I certify that all Information provided by me in connection with the Applications is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify J&C (and its Client, if requested) within 10 days of any material changes to the Information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided or authorized to be released to Agents in connection with the Applications.

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

APPLICANT'S SIGNATURE: _____ **DATE (MM/DD/YY):** _____

Print Name: _____

 JacksonCoker.com | 3000 Old Alabama Road Suite 119-608 | Alpharetta, GA 30022 | phone 800.272.2707 | fax 800.936.4562