**Mid-Atlantic QuickCare, PLLC Office Use Only**

APPLICATION FOR EMPLOYMENT

|  |
| --- |
| **Approval Signature:** |
| **Hire Date:** | **Start Salary:** |

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|  |  |  |
| --- | --- | --- |
| NAME (LAST) | (FIRST) | (MIDDLE) |
| ADDRESS (STREET) | CITY |
| STATE - ZIP CODE | HOME PHONE | WORK PHONE |
| SOCIAL SECURITY NO. | E-MAIL ADDRESS | OTHER (CELL, ETC.) |
| DRIVER’S LICENSE NO. | STATE OF LICENSE | MARITAL STATUS |
| DATE OF BIRTH | BIRTHPLACE (CITY & STATE) | COUNTRY OF BIRTH |

Are you 18 or older? Yes No Are you legally eligible for employment in this country? Yes No

***(Proof of work authorization & identity will be required upon employment)***

Have you ever been employed by us before? Yes No

If Yes, when?

In what capacity?

List names of relatives in our employ and their relationship to you:

List any personal acquaintances in our employment: \_ Have you ever had any disciplinary actions or investigations against you by any licensing board? Yes No If Yes, please explain:

Has your license to practice in any state been relinquished, denied, limited, suspended, or revoked? \_Yes No If Yes, please explain:

Have you ever had a malpractice insurance claim filed against you? Yes No

If Yes, please explain:

Have you ever been convicted of a crime? Yes No

*(Such conviction may be relevant if job related, but does not automatically bar you from employment)*

If Yes, please explain:

# Medical or Professional training school & Year of Graduation:

 Year: \_

**Certification Number: State of Issue:**

(Please attach copy)

Effective Date:

Expiration Date:

**Specialty:**

**DEA Number** (Please attach copy):

# License # for VA: License # for NC:

(Please attach copy) (Please attach copy)

**EDUCATION HISTORY** (Please attach all relevant documents)

# Institution Degree Year Graduated

**MALPRACTICE POLICY:**

(Please attach copy)

Effective date:

Expiration date:

**Individual NPI number:**

(Please attach copy of NPI letter)

**CREDENTIALED INSURANCES:**

|  |  |  |  |
| --- | --- | --- | --- |
| **INSURANCE** | **PROVIDER ID #** | **INSURANCE** | **PROVIDER ID#** |
| VA MEDICARE: |  | ANTHEM BCBS of VA: |  |
| NC MEDICARE: |  | BCBS of NC: |  |
| RAILROAD MEDICARE: |  | UNITED: |  |
| VA MEDICAID: |  | AETNA: |  |
| NC MEDICAID: |  | CIGNA: |  |

**PLEASE ATTACH A RESUME INCLUDING ALL OF YOUR EDUCATIONAL INFORMATION AND PAST WORK HISTORY WITH REFERENCES.**

# I verify that the above stated information is correct and true to the best of my knowledge.

**Employee Signature: Date:**

In an emergency, we can contact:

1. Phone Number(s):
2. Phone Number(s):