Mid-Atlantic QuickCare, PLLC

Office Use Only

APPLICATION FOR EMPLOYMENT

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

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): _____