

Send Us Your CV

Fax or mail your completed application to:

314.996.7658

BJC HealthCare

Physician Recruitment

Suite 300

670 Mason Ridge Center Drive

St. Louis, Missouri 63141 USA

Contact Information

first name _____ middle initial _____

last name _____

address _____

(address line 2) _____

city _____ state _____

ZIP code _____

telephone _____

pager _____

cell phone _____

e-mail address _____

How do you prefer to be contacted?

telephone

pager

cell phone

e-mail (*check boxes*)

specialty _____

current position _____

position applying for _____

date available _____

Curriculum Vita

Please send us your curriculum vita and explain any gap in chronology. Leave no time period unaccounted for within the last ten years.

Please answer the following questions with a Yes or No

Has your license to practice in this state or any other state been denied, restricted, limited, suspended or revoked; have you ever been reprimanded by a state licensing agency, or are any of these actions pending with respect to your license?

Yes No (*check boxes*)

Has your DEA or BNDD registration ever been restricted, limited, suspended or revoked; or are any of these actions pending with respect to your DEA or BNDD registration?

Yes No (*check boxes*)

Have your hospital privileges ever been revoked, suspended, reduced, not renewed; have disciplinary proceedings ever been instituted against you; or are any of these actions now pending with respect to your hospital privileges?

Yes No (*check boxes*)

Have you ever voluntarily relinquished hospital privileges, DEA, BNDD registration, academic appointments or any other professional status while an investigation was conducted?

Yes No (*check boxes*)

Has your participation in Medicare, Medicaid or other government program ever been denied, suspended or revoked; or -- to the best of your knowledge -- have you ever been -- or are you -- under investigation by a regulatory agency?

Yes No (*check boxes*)

Have any complaints been filed against you with a medical society?

Yes No (*check boxes*)

Has your professional liability insurance ever been canceled or has professional liability insurance ever been denied?

Yes No (*check boxes*)

Have you ever been convicted of a crime or do you have any felony or misdemeanor charges pending -- other than traffic offenses?

Yes No (*check boxes*)

Have you ever practiced in a geographic area other than the one in which you are now practicing, other than during training?

Yes No (*check boxes*)

If yes, provide the name and address of the hospital(s) where you had privileges.

hospital name _____

address _____

(address line 2) _____

city _____ state _____

ZIP code _____

hospital name _____

address _____

(address line 2) _____

city _____ state _____

ZIP code _____

Please provide an explanation for any yes answer.

Professional Liability History

List any professional suits or arbitrations over the past 10 years that are either pending -- or went to final disposition or settlement -- and resulted in payment to the plaintiff.

I have none. (*check box*)

date of incident _____

date of settlement _____

professional liability insurer involved _____

number of defendants _____

allegations _____

describe your role in the incident _____

briefly describe diagnosis, treatment and patient outcome _____

settlement amount _____

patient's first name _____ middle initial _____

last name _____

other defendants _____

date of incident _____

date of settlement _____

professional liability insurer involved _____

number of defendants _____

allegations _____

describe your role in the incident _____

briefly describe diagnosis, treatment and patient outcome _____

settlement amount _____

patient's first name _____ middle initial _____

last name _____

other defendants _____

date of incident _____

date of settlement _____

professional liability insurer involved _____

number of defendants _____

allegations _____

describe your role in the incident _____

briefly describe diagnosis, treatment and patient outcome _____

settlement amount _____

patient's first name _____ middle initial _____

last name _____

other defendants _____

Licensure

List all states that you are -- or have been -- licensed in, including license number and status.

state _____

license number _____

status _____

expiration _____

state _____

license number _____

status _____

expiration _____

state _____

license number _____

status _____

expiration _____

BNDD

state _____

registration number _____

status _____

expiration _____

DEA

registration number _____

status _____

expiration _____

ECFMG

standard ECFMG certificate _____

Board Certification

Board Specialty

Certified by ABM SAOA (*check boxes*)

Eligible (*check box*)

Anticipated date to sit for certification _____

Credentialing Authorization and Release

As an applicant for employment to the Physician Groups, LC, d/b/a BJC Medical Group and/or Children's Health Care Group ("Medical Group"), I hereby certify:

1. I authorize Medical Group and any Medical Group representative to:

- Consult or make inquiry of any and all individuals and organizations, including but not limited to physicians, hospitals, medical schools, medical training programs, medical organizations, specialty boards, licensing authorities, professional liability insurance carriers, brokers or agents, and personal references with whom I have been associated or who may have information bearing on my ability, training, education, professional ethics, character or competency, professional liability experience, and any other

qualifications pertinent to my application to the Medical Group

- Inspect and obtain copies of any records, documents and other information from any of the above referenced sources considered material by Medical Group or any Medical Group Representative for an evaluation of my professional or ethical qualifications

2. I hereby release:

- Medical Group and Medical Group Representatives for acts performed in connection with evaluating me and my credentials, including any decision to deny employment
- All individuals and organizations, including but not limited to, physicians, hospitals, medical schools, medical training programs, medical organizations, specialty boards, licensing authorities, professional liability insurance carriers, brokers or agents, and personal references, who provide information, whether written or oral, including otherwise privileged or confidential information, to Medical Group or any Medical Group Representative concerning my ability, training, education, professional ethics, character, competency, professional liability experience and any other qualifications pertinent to my application for employment

3. I acknowledge that, as an applicant, I have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications for employment and for resolving any doubts about such qualifications and that the failure to produce this information will prevent my application from being evaluated and acted upon.

4. I certify that all information given by me in this application or otherwise in connection therewith is true and correct without omission of any kind.

5. I understand and acknowledge that any significant mis-statements or omissions from this application may constitute cause for denial of employment or cause for termination of employment.

For purposes of this application and the authorizations and releases contained herein, the term "Medical Group Representative" shall include:

- BJC HealthCare and Washington University and their respective affiliates
- Directors, officers, employees and agents of Medical Group and either of the entities referenced in (1) above (including the employees of such agents)

A photocopy of this form shall suffice as an original for purpose of authorizing release of information.

signature _____ date _____

print name _____

address _____

(address line 2) _____

city _____ state _____

ZIP code _____

social security number _____

date of birth _____

Professional References

Please provide the names of at least four professional references. If you are a resident, at least one of these references should be a program director, assistant or associate director, or department chair.

Reference 1

first name _____ middle initial _____

last name _____

title _____

address _____

(address line 2) _____

city _____ state _____

ZIP code _____

telephone _____

fax _____

e-mail address _____

Reference 2

first name _____ middle initial _____

last name _____

title _____

address _____

(address line 2) _____

city _____ state _____

ZIP code _____

telephone _____

fax _____

e-mail address _____

Reference 3

first name _____ middle initial _____

last name _____

title _____

address _____

(address line 2) _____

city _____ state _____

ZIP code _____

telephone _____

fax _____

e-mail address _____

Reference 4

first name _____ middle initial _____

last name _____

title _____

address _____

(address line 2) _____

city _____ state _____

ZIP code _____

telephone _____

fax _____

e-mail address _____

comments, questions or additional background information
