Adaptive Solutions Multi Services(SLP, OT, PT, Psy) PLLC

APPLICATION FOR APPOINTMENT TO THE PROFESSIONAL STAFF

IDENTIFYING INFORMATION	LAST NAME FIRST NAME MIDDLE BIRTHPLACE DATE OF BIRTH HOME ADDRESS CITY STATE ZIP CODE TELEPHONE NUMBER CITEZENSHIP SOCIAL SECURITY NUMBER
MEDICAL INFORMATION	ON A SEPERATE SHEET. FURNISH THE DATE OF LAST PHYSICAL EXAMINATION. SIGNIFICANT FINDINGS. NAME OF PHYSICIAN AND/OR INSTUTION WHERE PERFORMED.
UNDER GRADUATE EDUCATION	COLLEGE OR UNIVERSITY DEGREE HONORS ADDRESS DATE OF GRADUATION
GRADUATE EDUCATION	COLLEGE OR UNIVERSITY DEGREE HONORS ADDRESS DATE OF GRADUATION
INTERNSHIP	ORGANIZATION ADDRESS DATES TYPE OF INTERNSHIP
RESIDENCES/ FELLOWSHIPS	LIST ALL FOLLOWSHIPS, TEACHING APPOINTMENTS. POST GRADUATE EDUCATION IN CHRONOLOGICAL ORDER. INCLUDING DATES, LOCATIONS, TYPE OF PROGRAMS, AND PRACTIONER RESPONSIBLE FOR PERFORMANCE.
	NAME AND ADDRESS DATES TYPE OF PROGRAM PRACTITIONER RESPONSIBLE FOR PERFORMANCE NAME AND ADDRESS DATES TYPE OF PROGRAM PRACTICIONER RESPONSIBLE FOR PERFORMANCE
CONTINUING PROFESSIONAL EDUCATION	ON A SEPERATE SHEET, LIST ALL POST GRADUATE ACTIVITIES WHICH YOU HAVE ATTENDED, OR FOR WHICH YOU HAVE RECEIVED CREDIT IN THE PAST TWO YEARS. FURNISH A LIST OF SCIENCTIFIC PAPERS OR ESSAYS YOU HAVE WRITTEN, AND A LIST OF SCIENTIFIC MEETING YOU HAVE ATTENDED IN THE LAST THREE YEARS
AFFILIATIONS	LIST ALL PRESENT AND PREVIOUS INSTITUTIONAL AFFILIATIONS AND CLINICAL STAFF MEMBERSHIPS IN CHRONOLOGICAL ORDER NAME AND LOCATION OF INSTITUTION CAPACITY DATES NAME AND LOCATION OF INSTITUTION CAPACITY DATES NAME AND LOCATION OF INSTITUTION CAPACITY DATES
PROFESSIONAL ASSOCIATIONS	LIST ALL PROFESSIONAL ASSOCIATION (USE SEPERATE SHEETS, IF NECESSARY)

Our policy is to provide equal employment opportunity to all qualified persons without regard to race, creed, color, religious belief, sex, age, national origin, ancestry, physical or mental handicap, or veteran status.

Adaptive Solutions Multi Services(SLP, OT, PT, Psy) PLLC

RESUME	PLEASE ATTACH A COPY OF YOUR CURRENT RESUME.		
PROFESSIONAL CERTIFICATION	TYPE OF CERTIFICATION	DATE OF CERTICIFATION	CERTIFICATE #
	TYPE OF CERTIFICATION	DATE OF CERTICIFATION	CERTIFICATE #
	TYPE OF CERTIFICATION	DATE OF CERTICIFATION	CERTIFICATE #
LICENSING Attach copy of license And registration	PROFESSIONAL LICENSURE (LIST ALL STATES. USE OTHER SIDE IF NECESSARY	DATE LICENSE NO.	REGISTRATION NO.
PROFESSIONAL REFERENCES	APPLICANTS MUST LIST THREE REFERENCES: (REFERENCES SHOULD COME FROM OTHER PROFESSIONALS WHO HAVE PERSONAL KNOWLEDGE OF THE APPLICANT'S CURRENT ABILITY, ETHICAL CHARACTER AND ABILITY TO WORK COOPERATIVELY WITH OTHERS).		
	PROFESSIONAL	ADDRESS	
	PROFESSIONAL	ADDRESS	
	PROFESSIONAL	ADDRESS	

PLEASE CHECK YES OR NO

LIABILITY INSURANCE	ON A SEPARATE SHEET, LIST ALL PREVIOUS INSURANCES CARRIERS. AMMOUNT OF COVERAGE, AND DATES:	
	HAVE JUDGEMENTS OR SETTLEMENTS BEEN MADE AGAINST YOU IN PROFESSIONAL LIABILITY CASES OR ARE THERE ANY PENDING? YES	NO
IF ANSWER TO ANY OF THE FOLLOWING QUESTIONS "YES" PLEASE GIVE FULL DETAILS ON A SEPARATE SHEET OF PAPER:		
A. HAS YOUR LICENSE TO PRACTICE YOUR PROFESSION IN ANY JURISDICTION EVER BEEN LIMITED SUSPENDED, REVOKED? YES		NO
B. HAVE YOU EVER BEEN REFUSED MEMBERSHIP ON ANY PROFESSIONAL STAFF? YES		NO
C. HAS YOUR REQUEST FOR ANY SPECIFIC CLINICAL PRIVILEGES EVER BEEN DENIED OR GRANTED WITH STATED LIMITATIONS? YES		NO
D. HAVE YOUR PRIVILEGES AT ANY INSTITUTION EVER BEEN SUSPENDED. DIMINISHED REVOKED OR NOT RENEWED? YES		NO
E. HAVE YOU EVER BEEN DENIED MEMBERSHIP OR RENEWAL OR BEEN SUBJECT TO DISCIPLINARY ACTION IN ANY PROFESSIONAL ORGANIZATION? YES		NO
F. HAVE YOU EVER BEEN DISCIPLINED BY THE OFFICE OF PROFESSIONAL MEDICAL CONDUCT (OPMC) OFFICE OF PROFESSIONAL DISCIPLINE (0PD) DEPARTMENT OF EDUCATION OR FEDERAL OR STATE PROFESSIONAL BOARD? YES		NO
G. HAVE YOU EVER BEEN OR ARE NOW ADDICTED TO, OR ABUSIVE OF DRUGS/ILLEGAL SUBSTANCES, OR ALCOHOLIC? YES		NO
H. HAVE YOU EVER ENTERED A PLEA OF GUILTY, OR HAVE YOU EVER BEEN CONVICTED OF ANY FELONY IN ANY STATE OR FEDERAL COURT? YES		NO
I. HAVE YOU EVER BEEN VOLUNTARILY OR INVOLUNTARILY RELINQUISHED ANY LICENSURE, REGISTRATION, OR PRIVILEGES TO ANY STATE AGENCY OR HOSPITAL? YE S		NO
a. HAS YOUR PROFESSIONAL LIABILITY INSURANCE COVERAGE EVER BEEN TERMINATED BY ACTION OF AN INSURANCE COMPANY? YES		NO
b. HAVE YOU EVER BEEN DENIED PROFESSIONAL LIABILITY INSURANCE COVERAGE? YES		NO
IF THE ANSWER TO QUESTION (a) OR (b) IS YES, STATE WHEN AND BY WHAT COMPANY: YES		NO
J . HAVE YOU EVER BEEN SUBJECT OF A MEDICARE OR MEDICAID INVESTIGATION, AUDIT OR OTHER REVIEW? YES		NO
K. DO YOU HAVE ANY REASONS FOR INABILITY TO PERFORM ESSENTIAL FUNCTIONS OF YOUR JOB? YES		NO

I HERBY APPLY FOR APPOINTMENT	FULL TIME _____ PART TIME_____	
PRIVILEGES REQUESTED	IN THE SPECIALTY OF: PHYSICAL THERAPTY _____ OCCUPATIONAL THERAPHY_____ SPEECH _____ _____EARLY CHILD HOOD EDUCATION (SPECIAL INSTRUCTION) _____ SOCIAL WORKER _____PSYCHIOLOGIST	

I affirm that the answers to the questions on this application are accurate and true to the best of my Knowledge

_____ _____ _____

SIGNATURE OF APPLICANT PRINT NAME DATE