
# Authorization to Release Information

Please read carefully:

I hereby authorize previous employers and references to furnish any information concerning my personal character, habits, or employment records to HCA and its affiliates. I also authorize HCA and its affiliates. to contact my present employer at a mutually agreed upon time.

HCA and its affiliates may conduct such investigations as may be necessary to confirm details of my background which are pertinent to the position for which I am result of inquiry and furnishing this information. A photocopy or fax of this authorization shall be considered as valid as the original.

_____
Applicant's Name (please print clearly)

_____
Applicant's Signature

_____
Applicant's Social Security Number

_____
Date

**Please return to:**

Amie Hoerath
HCA Physician Recruitment
(866) 517-8809 Fax

# CONSUMER AUTHORIZATION

I. I understand that an investigative report may be generated on me that may include information as to my character, general reputation, personal characteristics, or mode of living; work habits, performance or experience, along with reasons for termination of past employment/professional license or credentials; financial/credit history; or criminal/civil/driving record history. I understand that General Information Services, Inc. (GIS), on behalf of HCA or one of its affiliates may be requesting information from public and private sources about any of the information noted earlier in this paragraph in connection with HCA or one of its affiliates' consideration of me for employment, promotion or position re-assignment or contract now, or at any time during my tenure with HCA or one of its affiliates, and give my full consent for this information to be obtained.

II. IF APPLICABLE, medical and worker's compensation information will only be requested in compliance with the Federal Americans with Disabilities Act (ADA) and/or any other applicable state laws.

III. According to the **Fair Credit Reporting Act** (FCRA, Public Law 91-508, Title VI), I am entitled to know if the considerations for which I am applying are denied because of information obtained from a consumer reporting agency. If so, I will be notified and be given the name of the agency providing that report.

IV. I acknowledge that a telephonic facsimile (FAX) or photographic copy of this release shall be as valid as the original. This release is valid for most federal, state and county agencies.

V. I understand that if I am a resident of **Minnesota/Oklahoma (only)** I may obtain a copy of the report ordered, and now indicate my desire to do so by checking this box □.

VI. I hereby authorize, without reservation, any financial institution, law enforcement agency, information service bureau, school, employer or insurance company contacted by GIS to furnish the information described in Section I.

VII. Upon proper identification, you have the right to make a request to GIS, within a reasonable period of time, as to the nature and substance of all information in its files on you at the time of your request, including the sources of information and the recipients of any reports on you that GIS has previously furnished. Communications with GIS should be directed to PO Box 353, Chapin SC 29036 or (866) 265-4917.

**CANDIDATE COMPLETE THE FOLLOWING:**

_____ _____
Signature Today's Date

_____
Please print full name

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes.

_____ _____
Month, Day and Year of Birth Social Security Number

_____ _____
Home Address City State Zip

_____ _____
Driver's License Number and State Name as it appears on License

_____
Please provide all alternate name(s) used (i.e. maiden name or previous married names)

_____
Applicant Phone Number

Have you ever been convicted of a crime? ☐ No ☐ Yes If yes, please provide city, county, state, date of conviction and details of conviction.

_____

_____

_____

**Previous Addresses for the Last 7 Years (use additional page if needed)**

Street Address | City | State | Zip

Street Address | City | State | Zip

Street Address | City | State | Zip

**Professional Licensure**

Professional License Held | License Number and State Issued

Professional License Held | License Number and State Issued

DEA Certification Number and Expiration Date | Tax ID #

ECFMG Number

**Education - Please include any fellowships, residencies, and internships (use additional page if needed)**

High School | City, State

Dates Attended | Graduated? □ Yes □ No | Degree Earned – GED or Diploma | Name while attending

Institute Name / Undergrad School | City, State

Dates Attended | Graduated? □ Yes □ No | Degree Earned | Name while attending

Institute Name / Medical School | City, State

Dates Attended | Graduated? □ Yes □ No | Degree Earned | Name while attending

Facility Residency/Fellowship/Internship was completed (circle one) | City, State

Dates: To / From | Name while attending | Program

Facility Residency/Fellowship/Internship was completed (circle one) | City, State

Dates: To / From | Name while attending | Program

**Employment to cover up to 7 years (attach additional page if needed) - If employed through an Agency, please provide the Agency name instead of the company name or hospital.**

**1. Employer Name** | City, State | Phone Number

Dates: To / From | Job Title | Reason for Leaving

**2. Employer Name** | City, State | Phone Number

Dates: To / From | Job Title | Reason for Leaving

**3. Employer Name** | City, State | Phone Number

Dates: To / From | Job Title | Reason for Leaving

**4. Employer Name** | City, State | Phone Number

Dates: To / From | Job Title | Reason for Leaving

**FAIR CREDIT REPORTING ACT NOTICE:**
In accordance with the Fair Credit Reporting Act (FCRA, Public Law 91-508, Title VI), this information may only be used to verify a statement(s) made by an individual in connection with legitimate business needs. The depth of information available varies from state to state . Status of updates are available on request. Although every effort has been made to assure accuracy, General Information Services, Inc. cannot act as guarantor of information accuracy or completeness. Final verification of an individual's identity and proper use of report contents are the user's responsibility. General Information Services, Inc.'s policy requires purchasers of these reports to have signed a Service Agreement. This assures General Information Services, Inc. that users are familiar with and will abide by their obligations, as stated in the **FCRA**, to the individuals named in these reports. If information contained in this report is responsible for the suspension or termination of an employee or the application process, have the Candidate/employee contact General Information Services, Inc.

NOTICE TO CALIFORNIA CANDIDATES

You have a right to obtain a copy of any consumer report or investigative consumer report obtained by HCA or one of its affiliates by checking the box provided below. The report will be provided to you within three (3) business days after we receive the requested reports related to the matter investigated.

□ I request to receive a free copy of this report by checking this box.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by GIS during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at GIS in person or by mail. You may also receive a summary of the file by telephone. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.

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## DISCLOSURE QUESTIONS

**PLEASE PROVIDE A COMPLETE, SIGNED AND DATED EXPLANATION ON A SEPARATE SHEET IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED IN THE AFFIRMATIVE.**

1. ☐ Yes ☐ No Has your **professional license or registration** ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished, or not renewed by any licensing board of any health-related agency or organization, or is there a review pending?

2. ☐ Yes ☐ No Has your **DEA registration** ever been revoked, suspended, limited, or conditioned in any way, or have you ever voluntarily relinquished your DEA registration, or is there a review pending?

3. ☐ Yes ☐ No Has your **membership, participation, clinical privileges, or employment** ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?

4. ☐ Yes ☐ No Have you ever voluntarily or involuntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license, or registration as an alternative to disciplinary action, or prior to or during an investigation into your professional conduct or competence?

5. ☐ Yes ☐ No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any **licensing board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization**?

6. ☐ Yes ☐ No Has your certificate or participation in any **private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?

7. ☐ Yes ☐ No Are there any **charges pending or are you currently charged with** or have you ever been indicted or found guilty of a felony, misdemeanor (other than a minor traffic violation), **or other offense involving** fraud, misrepresentation, dishonesty or deceit?

8. ☐ Yes ☐ No Have you ever been the **subject or target of a sexual harassment complaint** or investigation or other complaint or investigation involving sexual misconduct or impropriety?

9. ☐ Yes ☐ No Have you ever had any **professional liability claims or lawsuits** brought against you, including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments? **If yes, please complete the enclosed Professional Liability Addendum. You may be asked for additional information by individual organizations.**

10. ☐ Yes ☐ No Has your **professional liability carrier** ever refused or canceled your coverage?

11. ☐ Yes ☐ No **Have you ever been convicted of using illegal drugs?**

12. ☐ Yes ☐ No **Have you ever been convicted of driving under the influence?**

13. ☐ Yes ☐ No **Do you have any reason to believe that you may not be able to obtain hospital privileges?**

## ATTESTATION SIGNATURE AND DATE

I hereby certify that all the information on this application form is complete, true and accurate.

**Signature** _____ **Date** _____

**Name** _____
(please print or type)

## PROFESSIONAL LIABILITY ADDENDUM
## TO INITIAL/REAPPOINTMENT APPLICATIONS

**If you answered yes to disclosure question #9, please provide the following detailed information for each malpractice claim brought against you, including pending claims, lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments. (Please make additional copies of this page if needed.)**

Claim #1

| Date of Occurrence | Amount paid/in reserve to resolve claim | Institution Involved (i.e. hospital, etc.) |
|---|---|---|
| | | |
| **Name of Insurance Carrier** | | |
| | | |
| **Insurance Carrier Address/City/State/Zip** | | |
| | | |
| **Current status of claim (open/closed/pending/resolved, etc.)** | | **Date Closed** |
| | | |
| **Details of Allegations** | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Claim #2

| Date of Occurrence | Amount paid/in reserve to resolve claim | Institution Involved (i.e. hospital, etc.) |
|---|---|---|
| | | |
| **Name of Insurance Carrier** | | |
| | | |
| **Insurance Carrier Address/City/State/Zip** | | |
| | | |
| **Current status of claim (open/closed/pending/resolved, etc.)** | | **Date Closed** |
| | | |
| **Details of Allegations** | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Signature:** _____ **Date:**
**Print Name:**

# PROFESSIONAL REFERENCES

List at least three professional peers who have current knowledge of your skills, abilities, judgment, professional performance and clinical competence or have been responsible for professional observation of your work. Please limit to one office associate.

**Physicians:** Please list other physicians.
**Mid-level providers:** Please list equivalent providers and/or physicians.

| Name/Relationship | Address/City/State/Zip | Phone | FAX |
|---|---|---|---|
| | | | |
| | | | |
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| | | | |

I authorize HCA and its affiliates to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, ethics, behavior or any matter reasonably having a bearing on my qualifications and authorize such third parties to release information to **HCA.**

**Signature:** _____ **Date:**

**Name:**
(please print or type)

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PHYSICIAN SERVICES