LCA

LOW COUNTRY ANESTHESIA, P.A.

Anesthesiologist Application

Date of Application: _____

I. Personal Information:

Full Name _____ Nickname_____

Address_____

City _____ State _____ Zip _____ County _____

Home Phone _____ Cell Phone _____

Email _____ Pager_____

Social Security No. _____

U.S. Citizen: Yes___ No___ City/State/Country of Birth _____

If Incorporated: Business Name _____ Tax ID No. _____

Maiden and/or Former Name(s) _____

II. Education and Licensure:

College _____ Year Completed _____ Degree _____

Medical School _____ Year Completed _____ Degree _____

Anesthesia _____ Year Completed _____ Degree _____

Other Training _____ Year Completed _____ Degree _____

State(s) of Current & Past Licensure _____

State of Original License _____ Pending Licenses _____

Malpractice Carrier _____ Policy Limits_____

III. Types of Cases Comfortable With:

Ortho___ Neuro___ Hearts___ Major Vascular___ Thoracic___ URO___ OB___ GYN___

Eyes___ Burns___ Trauma___ Transplants___ Abortions___ GER___ ENT___ PEDS___

Other Cases: _____

Low Country Anesthesia, P.A. - Attn: HR
P.O. Box 2118
Beaufort, SC 29901

IV. Complete Practice History (use additional pages if necessary):

Name of Hospital or Facility		Dates Employed
Title & Responsibilities		
Supervisor or Medical Director	Address	Phone or Email
Name of Hospital or Facility		Dates Employed
Title & Responsibilities		
Supervisor or Medical Director	Address	Phone or Email
Name of Hospital or Facility		Dates Employed
Title & Responsibilities		
Supervisor or Medical Director	Address	Phone or Email
Name of Hospital or Facility		Dates Employed
Title & Responsibilities		
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V. Background (If you answer "Yes" to any of the following questions, please provide complete details on a separate sheet):

Do you have any limitation that would hinder your performance as an anesthesiologist? Yes___ No___

Do you require an accommodation to work as an anesthesiologist Yes___ No___

Have you ever been convicted of a felony or crime other than a traffic violation? Yes___ No____

Have your privileges at any healthcare facility ever been voluntarily or involuntarily denied, relinquished, suspended, diminished, revoked, or not renewed for any reason? Yes___ No___

Have you ever been the subject of a disciplinary proceeding(s), regardless of outcome, at any healthcare facility? Yes___ No___

Has your license or certification in any state ever been voluntarily or involuntarily relinquished, suspended, terminated, restricted, or is currently being challenged? Yes___ No___

Have you ever been the subject of a disciplinary proceeding(s), regardless of outcome, by any state licensure board? Yes___ No___

Have you ever been suspended, terminated, sanctioned or otherwise restricted from participating in any private, public, federal, or state health insurance program (e.g., Medicare, Medicaid, Blue Shield, etc.)? Yes___ No___

Have judgments or settlements been made against you in a professional liability case(s), or is(are) claim(s) pending? Yes___ No___

Are you board certified as an Anesthesiologist? Yes__ No__ Certification #: _____

VI. Please Include Clear Copies or Photos of the Following Material with Your Completed Application:

___ Resume or Curriculum Vitae

___ Three (3) Letters of Reference or Reference Inquiry Forms (part of this application)

___ Social Security Card

___ Current Driver's License or State Issued Photo Identification

___ NPI Confirmation – Individual or Group

___ Medicare / Medicaid / Blue Cross Numbers

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VII. Applicant's Statement of Confirmation and Release:

The facts set forth in this application for employment with Low Country Anesthesia, P.A., are true and complete. False statements on this application shall be considered sufficient cause for dismissal. Low Country Anesthesia, P.A. and its representatives are hereby authorized to make any investigations of my personal and professional history through any agency, bureau or other organization necessary, including but not limited to, criminal background and criminal reports. Low Country Anesthesia, P.A. and its representatives are also authorized to investigate my ability, employment records, or character through inquiries to the individuals and/or employers mentioned in this application. **I understand that Low Country Anesthesia, P.A. has the right to request a drug screen prior to and during any employment.**

Signature: _____ Date: _____

Printed Name: _____ Social Security No.: _____

Low Country Anesthesia, P.A. (LCA) is an Equal Opportunity Employer. LCA does not discriminate on the basis of race, gender, religion, age, sexual orientation, gender identity, nationality or ethnicity, disability, marital or veteran status, or any other classification protected by applicable law. LCA also complies with laws regarding reasonable accommodations for individuals with disabilities. **Nothing in the application should be construed as an offer or guarantee of employment.**

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APPLICANT'S STATEMENT OF CONSENT AND RELEASE

I hereby authorize Low Country Anesthesia, P.A. and its representatives to consult any person or organization and to inspect any materials having or containing information which may have any bearing on my professional, ethical, and moral qualifications, including my personal character and professional competence. I hereby authorize Low Country Anesthesia, P.A. and its representatives to request such criminal background histories, drug screen tests and credit reports as Low Country Anesthesia, P.A. deems appropriate. I hereby appoint Low Country Anesthesia, P.A.and its representatives my attorney in fact to request any such criminal, credit, drug, professional, and personal reports, at any time, without the need to seek further authorization from me. I hereby agree that this authorization and appointment shall be valid until revoked by me in a written revocation delivered to Low Country Anesthesia, P.A. I hereby release from liability Low Country Anesthesia, P.A. and its representatives for all acts performed in connection with evaluating my application for employment. **I hereby release from liability all persons and organizations who furnish information concerning my professional competence, ethics, character, and other qualifications, and consent to the release of such information.**

Signature: _____ Date: _____

Printed Name: _____

NOTE TO APPLICANT: You should provide a signed copy of this Statement of Consent and Release to each reference who will be completing the attached Reference Inquiry Form or preparing a letter of reference on your behalf. A signed copy of this Statement should also be provided to Low Country Anesthesia, P.A. with your other application materials.

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Reference Inquiry Form

Low Country Anesthesia, P.A., ("LCA") is a private anesthesiology group who practices in South Carolina. LCA strives to deliver the highest quality medical care to our patients. In order to fulfill this mission, LCA and its representatives thoroughly screen every candidate for employment. We recently spoke to the below named candidate who directed us to you for your professional and personal opinions. Please take a moment to complete this evaluation form and return it to LCA at the address listed below. Thank you in advance for your assistance.

Candidate's Name: _____

Reference's Name: _____ Phone: _____

Title: _____ Email: _____

Hospital/Group: _____ Fax: _____

Address: _____

Dates of Candidate's Employment: _____

Was Candidate Terminate? Yes___ No___ Would You Rehire? Yes___ No___

Were There Any Suspected Problems with Drugs, Alcohol, Nerves, etc? Yes___ No___

If Yes to any of the Above, Please Explain: _____

_____

Please Evaluate the Candidate Below According to the Following Scale:

A = Above Average **B** = Average **C** = Below Average **D** = Unacceptable

_____ Adaptability to Work Situations

_____ Rapport with Physicians, Coworkers and Patients

_____ Assessment and Management of "High Risk Patients"

_____ Seeks Consultation When Necessary

_____ Overall Professional Competence

_____ Emotional Stability

_____ Attitude

_____ Technical Skill

_____ Personal Appearance

____ Attendance/Punctuality

Comments: _____

_____

Signature: _____ Date: _____

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