Application for Affiliation

1. **Please fill out this application completely.**
2. **Include copies of your medical/nursing school diploma, licenses (state and DEA), board certification.**
3. **Be sure your passport is current.**

____
Date

Name ____________________ Home Phone Number ____________________

Home Address ____________________ Home Fax Number ____________________

City ________ State ________ Zip+4 ________ Work Phone Number ____________________

Primary Office Address ____________________ Work Fax Number ____________________

City ________ State ________ Zip+4 ________ Bpr/Ans Svc Number ____________________

Place of Birth ____________________ Date of Birth ______/______/______

Citizenship ____________________ Social Security Number ____________________

Current Employer

Name ____

Address ____

Phone Number ____________________ Immediate Supervisor ____________________

Education

Undergraduate School ____________________ Graduate School ____________________

City ________ State ________ City ________ State ________

Year Graduated ________ Degree ________ Year Graduated ________ Degree ________

Post Graduate Education/Training ____________________ City ________ State ________

Residency: *Type* *Hospital* *Dates*

1st year____

2nd year____

3rd year____

4th year____

5th year____

Please list all states and countries in which you have or have had a medical license and your license number in each:

____

____

Board certified in:__________________ Board eligible in:____________________ Medicare UPIN #:__________

Current malpractice insurance carrier and address:____

____

Have you had experience in shipboard medicine? If so, please tell us about it (dates, ship lines, etc.):___________

____

Do you have a U.S. Coast Guard Certificate of Registry (Z-card)?____ If so, what is the expiration date?_________

Have you had experience sailing or cruising? If so, what?____

____

What foreign languages do you speak?____

Employment History (last 10 years)

Name of Employer Address Job Dates

1____

2.____

3.____

4____

List all hospitals (with address and telephone number) at which you now have privileges

1.____

____

2.____

____

3.____

____

Professional associations, memberships:____

What was the date of your last ACLS course or recertification?___/____/____ ATLS?____/_____/_____

Have your clinical privileges at any hospital been suspended, diminished, or revoked? Y N
Have you ever been disciplined or reprimanded at any educational hospital or medical institution? Y N
Have you ever had any professional/medical license suspended, limited, or revoked by a state board or agency? Y N
Has your federal or state drug license ever been suspended, revoked, or limited? Y N
Do you have any physical impairment which might limit your ability to practice? Y N
Have you ever had or been treated for drug or alcohol dependency? Y N
Have judgements/settlements been made against you in any medical liability cases, or are there claims pending? Y N
If the answer to any of the above questions is "Yes", then please submit details (on a separate sheet if necessary).

____

____

____

____

Do you have any physical disabilities? of hearing:____

of sight:____corrected vision: OD_____ /_____ , OS___/___

of movement:____

What was the date of your most recent Chest Xray?___/____/___ of your most recent TB skin test?___/___/___

Please give the names, addresses, and phone numbers of three references who are familiar with your current practice.

1.____

____

2.____

____

3.____

____