Malta House of Care - Waterbury, Inc.
P.O. Box 247
Middlebury, CT 06762
Phone/Fax: (203) 758-1037

Volunteer Physician/Physician Assistant/ APRN Application

Name: _____ SSN#: _____ Date: _____

Office Address: _____

City/State: _____ Zip: _____

OfficeNo.: _____ Fax No.: _____

Residence: _____

City/State: _____ State/Zip: _____

Home No.: _____ Home Fax: _____

Cell Phone: _____ Language(s) spoken: _____

Preferred place of contact: _____ Email: _____

Preferred Work Day: Monday Tuesday Wednesday Thursday

Emergency Contact Information: _____
Name

_____
Phone

_____
Relationship

In completing this application, the following items must be mailed to: Malta House of Care - Waterbury, Inc. P.O. Box 247, Middlebury, CT 06762. ***Please mark confidential***

1. Application
2. Copy of current Connecticut license and DEA License.
3. Copy of a government issued photo ID (e.g. drivers license)
4. Signed Statement of Confidentiality and Professional Questions and Attestation Sheet.
5. Signed Background Check form
6. Signed Release of Medical Staff Records form for Providers in active practice.

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Name of Applicant: _____

Current Medical (APRN) License#_____ State:_____

Date Licensed:_____ Expiration Date:_____

Federal DEA# _____ Exp. Date_____

Are you Board Certified? ☐ Yes ☐ No If "Yes," name of approved specialty board(s)/certification(s):_____

Date of Certification: _____ Is re-certification required? ☐ Yes ☐ No
If "Yes," date of anticipated re-certification:_____

Are you Board Eligible? ☐ Yes ☐ No If "Yes," anticipated date of certification:
_____

Where have your practiced your profession in the last eight (8) years?

_____	_____	_____
City/State	From: month/year	To: month/year
_____	_____	_____
City/State	From: month/year	To: month/year
_____	_____	_____
City/State	From: month/year	To: month/year

List all hospitals where you currently have staff privileges:

_____		_____	
Hospital	City/State	Hospital	City/State
_____		_____	
Hospital	City/State	Hospital	City/State
_____		_____	
Hospital	City/State	Hospital	City/State

Insurance Claims History: Please note the TORT application requires claim information ten (10) years back.

1. Have you had a malpractice claim within the last ten years? ☐ Yes ☐ No
   *If "Yes," please provide date of claim, payment and a brief summary of the allegations:

_____
_____
_____
_____

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MALTA HOUSE OF CARE – Waterbury, INC.
MALTA HOUSE OF CARE FOUNDATION, INC.

BACKGROUND CHECK

NOTIFICATION AND AUTHORIZATION

This is used to inform you that an investigative report is being obtained from a background investigation agency for the purpose of evaluating you for employment, volunteer service or a contracted position, including retention as an employee, volunteer or independent contractor.

This report may contain information bearing on your character, general reputation, and personal characteristics from public or private record sources. *Please keep in mind that our background check is limited to State Crime Files, Social Security Number Verification and National Sex Offender Registry. All authorization forms will be kept in the Office of the Director of Human Resources in a secured location.*

To Whom It May Concern:

I understand that an investigative report as described above may be obtained. All law enforcement agencies, State Police and courts are authorized to release to Mind Your Business, Inc. for the benefit of the Malta House of Care - Waterbury, Inc. and/or the Malta House of Care Foundation, Inc. and its entity that I serve all written information about me.
I give permission for a criminal background check to be conducted on me by Mind Your Business, Inc. for the benefit of the Malta House of Care - Waterbury, Inc. and/or the Malta House of Care Foundation, Inc. and its entity that I serve and hereby release all individuals, companies, corporations, and agencies, *public or private*, connected therewith from any and all liability associated with the proper dissemination of such information.

I have been given a copy of this form.

Print Name_____

Signature_____

Current Address_____

_____

Date of Birth (for identification purposes only)_____

Social Security Number_____

If name changed (through marriage or otherwise) print former name here_____

Employee ____ Volunteer ____ Dated: _____

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Professional History:

1. Have you ever been investigated, disciplines, censured, or reprimanded by a medical society, professional review board, or state licensing entity or board or had a complaint submitted to such entities? □ Yes □ No
   If "Yes," please explain: _____
2. Have your hospital privileges ever been restricted, denied, suspended or revoked?
   ☐ Yes ☐ No
3. Has any disciplinary actions/observations been taken against you? ☐ Yes ☐ No
   If "Yes," please explain: _____
4. Has your medical license ever been restricted, voluntarily suspended or revoked?
   ☐ Yes ☐ No
5. Do you have any personal health problems that might affect your ability to perform any aspect of your medical practice? □ Yes □ No
   If "Yes," please explain: _____

I agree to abide by the regulations, rules, policies and procedures of the Administration, Medical Director and Medical Advisory Committee, as well as any amendments added thereto.

I hereby declare that the above questions have been answered to the best of my ability and that I have not omitted any material facts and I agree that this application shall be the basis for any insurance policy that is issued.

_____
Printed name of applicant

_____ _____
Signature of applicant Date

Attestation Sheet

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1.	Has your license to practice in this state or any other state been denied, restricted, limited, suspended, revoked, or relinquished (either voluntarily or involuntarily) or are any of these actions pending with respect to your license? Have you been reprimanded by a state licensing agency?	❑ Yes	❑ No
2.	Has your DEA (state or federal) been denied, restricted, limited, suspended, revoked, or relinquished (either voluntarily or involuntarily) or are any of these actions pending with respect to your DEA registration?	❑ Yes	❑ No
3.	Has your medical staff membership or privileges at any hospital or other health care facility ever been denied, restricted, suspended, revoked, or relinquished (either voluntarily or involuntarily)? Have disciplinary proceedings been instituted against you? Are any of these actions pending with respect to your medical staff membership and/or hospital privileges?	❑ Yes	❑ No
4.	Have you voluntarily relinquished medical staff membership and/or hospital privileges, DEA registration, academic appointments or any other professional status while an investigation was being conducted?	❑ Yes	❑ No
5.	Has your participation in Medicare, Medicaid or other government programs been denied, restricted, limited, suspended, revoked, or relinquished (either voluntarily or involuntarily)? Have any monetary penalties been levied against you? Have you been or are you under investigation by a regulatory agency?	❑ Yes	❑ No
6.	Have any complaints been filed against you or have you ever been denied membership, or renewal thereof, or been subject to disciplinary action, with any Medical Society?	❑ Yes	❑ No
7.	Have any professional liability judgments been entered against you, including arbitration, or are there suits pending?	❑ Yes	❑ No
8.	Have any professional liability claim settlements, not involving litigation or arbitration, been paid by you or on your behalf?	❑ Yes	❑ No
9.	Has your professional liability insurance been cancelled, or has professional liability insurance been denied or premiums increased or surcharged based on claim history?	❑ Yes	❑ No
10.	Have you ever been notified that a report concerning you has been filed with the National Practitioner Data Bank (NPBD)?	❑ Yes	❑ No
11.	Have you been convicted of a crime (other than a traffic offense), or do you have any felony or misdemeanor charges pending other than traffic offenses?	❑ Yes	❑ No
12.	Do you presently have any condition that affects, or is reasonably likely to affect your ability to perform professional or medical practice duties appropriately?	❑ Yes	❑ No
13.	Do you presently have any condition that would require any recommendations in order to perform medical duties safely and efficiently?	❑ Yes	❑ No

Please provide an explanation for any question to which you responded Yes. Use a separate page, if necessary.

I certify that the above information in this document is complete and accurate, and I agree to provide information as required to support this document.

Signature **Degree** **Date**

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AUTHORIZATION TO RELEASE MEDICAL STAFF RECORDS

I, the undersigned practitioner, have made application to Malta House of Care – Waterbury Free Clinic to serve as a volunteer health care provider.

I hereby authorize _____to provide to Malta House of Care certain information from my credentialing file at the Hospital, including verification of my Connecticut license to practice medicine, DEA registration, medical school attendance, graduate and post graduate attendance, completion of residency and fellowships and current privileges. I hereby release and hold_____, harmless from any liability that may accrue as a result of the release of information which is the subject of this authorization.

I understand that I may revoke this authorization for the release of future information at any time by giving written notice to the Medical Staff Office at _____
_____
Such revocation shall be effective upon its receipt by the Medical Staff Office.

Signature: _____

Name *(Print)*: _____

Date: _____

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Statement of Confidentiality

I _____, agree to keep confidential any and all information regarding our patients, visitors, management staff, members of the Board of Directors, and employees which may become known to me by reason of employment or volunteerism with Malta House of Care - Waterbury, Inc., or Malta House of Care Foundation, Inc.

I understand that violation of this agreement may be considered grounds for immediate dismissal.

Signature_____

Date _____