



RADIATION ONCOLOGY  
CANDIDATE DATA SHEET

**IDENTIFYING INFORMATION**

Last Name		First	Middle Initial	Date of Birth	Birthplace
Home Address		City	State	Zip	Phone Number
Office Address		City	State	Zip	Phone Number
Social Security Number		Cell/Pager #	Office e-mail	Home e-mail	
Citizenship	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M	Spouse's Name	Emergency Contact Name	Emergency Contact Number	
Specialty	Year	Board Certified	Board Eligible/In Process	Not Eligible	
Sub-Specialty	Year	Board Certified	Board Eligible/In Process	Not Eligible	
Are you authorized to work in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Other Names Used?		

**EDUCATION AND TRAINING**

Facility/City/State	Degree/Type	From MM/YY To MM/YY
Medical School		
Internship (PGY-1)		
Residency		
Residency		
Fellowship		
<p>On a separate sheet of paper, please list your practice experience from the time you graduated medical school to the present including month and year. Your detailed Curriculum Vitae may be substituted if it doesn't contain any gaps in time.</p>		

**EXAMINATIONS/LICENSES/REGISTRATION**

Licensing Examination National Board <input type="checkbox"/> Flex <input type="checkbox"/>	In Which State?	# of Times Taken	Date Last Take	State Exams	Which States?		
SPEX <input type="checkbox"/> USMLE: Step I <input type="checkbox"/> Step II <input type="checkbox"/> Step III <input type="checkbox"/>							
Federal DEA# _____ Exp. Date: _____ UPIN# _____ NPI# _____ Medicare # _____							
1. Are you now, or have you ever been, under sanction or investigation with regard to Medicare and/or Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, please, explain:</b> _____							
2. Have you ever been credentialed through the FCVS (Federation Credentials Verification Service)? <input type="checkbox"/> Yes <input type="checkbox"/> No							
3. List <u>All States in Which You Have Been or Are Now Licensed &amp; Any State Controlled Substance License.</u>							
Original State License & Number _____		Issue Date _____	Expiration Date _____				
State	Number	Issue Date	Expiration Date	State	Number	Issue Date	Expiration Date



**PROFESSIONAL REFERENCES**

Please list four professional references that you have worked with within the last year; specifically, the references must be colleagues in your specialty, referring physicians or previous supervisors that you have had clinical contact with in the last twelve months.

Name	Hospital/Institution/Facility	Specialty	Work Phone
1.			
2.			
3.			
4.			

**MILITARY STATUS**

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Branch	Dates of Service
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**PROFESSIONAL INFORMATION**

<input type="checkbox"/> Yes	<input type="checkbox"/> No	1. Have any of the following been, or are in the process of being denied, revoked, suspended, reduced, limited, placed on probation, or under other disciplinary action?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	a. Medical license in any state
<input type="checkbox"/> Yes	<input type="checkbox"/> No	b. DEA or State Controlled Substance Registration
<input type="checkbox"/> Yes	<input type="checkbox"/> No	c. Membership and/or employment in any hospital Medical Staff
<input type="checkbox"/> Yes	<input type="checkbox"/> No	d. Clinical privileges
<input type="checkbox"/> Yes	<input type="checkbox"/> No	e. Participation in any private, federal or state health insurance program (Medicare, Medicaid, etc.)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	2. To your knowledge, have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state insurance program?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	3. Have you ever been the subject of investigative or disciplinary proceedings or been reprimanded by a government or administrative agency?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	4. Have you ever been convicted of a felony or misdemeanor?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	5. Is there any issue which should be disclosed that may have an adverse impact on your ability to deliver effective locum tenens physician services?
*If you have answered YES to any of the above questions, please reference and give full details on an attached sheet of paper.		

**LIABILITY INSURANCE – Please Include the Last Ten Years Malpractice History**

Current Insurance Carrier	Amount of Coverage	Expiration Date
Policy Number	Agent	Phone No.
Have past claims or settlements been made against you? <input type="checkbox"/> Yes <input type="checkbox"/> No    Are there any pending? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*If you have answered YES to any of the above questions, please reference and give full details on an attached sheet of paper.		



HEALTH STATUS

Date of your last physical examination: \_\_\_\_/\_\_\_\_/\_\_\_\_ Present Health Status:  Good  Fair  **Poor**

Yes  No 1. Do you presently have a physical or mental health condition that affects or is reasonably likely to affect your ability to perform professional or medical staff duties appropriately?

Yes  No 2. Are you currently taking any medications? If yes, please list and explain on a separate sheet of paper.

Yes  No 3. Have you at any time during the last 5 years been hospitalized or received any other type of institutionalized care for a physical or mental health problem?

Yes  No 4. Are you currently under the care of a physician?

Yes  No 5. Have you ever been denied or do you have any limitations on your health, life or disability insurance?

Yes  No 6. Have you ever tested positive for Hepatitis B?

Yes  No 7. Have you ever been dependent on alcohol or drugs?

Yes  No 8. Are you currently under any limitations, in terms of activity or workload?

Yes  No 9. Have you ever tested positive for HIV?

Yes  No 10. Have you ever tested positive for TB?

\*If you have answered YES to any of the above questions, please reference the question and give full details on an attached sheet of paper.

TELL US ABOUT YOU

1. How soon would you be interested in working on a locums basis with Cancer CarePoint, Inc.? \_\_\_\_\_

2. Initially, how many locum tenens weeks per year would you like to work? \_\_\_\_\_

3. Which of the following are reasons you would most like to work on a locums basis with Cancer CarePoint, Inc.?

<input type="checkbox"/> to be selective in accepting a permanent position	<input type="checkbox"/> to explore different practice styles
<input type="checkbox"/> to explore different practice opportunities	<input type="checkbox"/> to wind down career while keeping skills sharp
<input type="checkbox"/> to gain private practice experience while looking for the right job	<input type="checkbox"/> to supplement income
<input type="checkbox"/> for the adventures of traveling all over the country	<input type="checkbox"/> for fewer day-to-day administrative responsibilities
<input type="checkbox"/> as a "stopgap" measure while waiting to start a new position	

PLEASE READ, SIGN AND DATE

I hereby affirm that the information provided by me on this application and attachments can be used by Cancer CarePoint, Inc. (CCP) to evaluate my potential candidacy is true, complete, and correct and that CCP will rely on the truthfulness of my statements. I further acknowledge that: 1. The decision to offer me a position with CCP is solely at the discretion of CCP; 2. Any information received from references by CCP is confidential and may not be released to me without the consent of the references; 3. I hereby authorize and consent to the release of information by physicians, hospitals and other references to CCP and its professional liability insurance carrier and hold them harmless for the good faith release of information regarding my professional capabilities and performance and agree that other sources not listed by me can be contacted; 4. I agree that I will not enter into an arrangement to provide temporary or permanent physician services with any individual, group or institution to whom I am referred by CCP, except through CCP or with CCP's consent.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

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