



RADIATION THERAPY
CANDIDATE DATA SHEET

IDENTIFYING INFORMATION

Last Name		First		Middle Initial	
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
Date of Birth		Birthplace			
Citizenship		Marital Status <input type="checkbox"/> S <input type="checkbox"/> M		Spouse's Name	
Emergency Contact Name			Emergency Contact Number		
Board Certified <input type="checkbox"/> Yes <input type="checkbox"/> No		Year	Board Eligible/In Process <input type="checkbox"/> Yes <input type="checkbox"/> No		Year
If NOT currently certified, have you applied for the examination? If yes, how many times?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever taken a certification examination and failed to pass? If yes, when are you scheduled to take the exam?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
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
Undergraduate		
Masters		
Doctorate		
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.		

LICENSES

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.

Signature _____ Date _____

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