



Mountain Comprehensive Health Corporation

**Professional
Application For Employment**
"An Equal Opportunity Employer"

Please Return Completed Application to:

**Mountain Comprehensive Health Corporation
226 Medical Plaza Lane
PO Box 40
Whitesburg, Kentucky 41858**

FOR OFFICE USE ONLY

APPLICATIONS WILL BE KEPT ON FILE FOR A PERIOD OF ONE YEAR

MOUNTAIN COMPREHENSIVE HEALTH CORPORATION

Professional Application For Employment

I hereby make application for consideration by Mountain Comprehensive Health Corporation. My chief professional interest is in the field of: _____

PERSONAL

Name _____
Last First Middle

Home Address _____
Street City State Zip County

Home Phone _____

Office Address _____
Street City State Zip County

Office Phone _____

Citizen Of: _____ Social Security # _____

EDUCATION

1. Premedical Education - colleges attended, dates, degrees:

College	Address	Degree	Date

2. Medical Education - schools attended, dates and degrees:

Medical School	Address	Degree	Date

3. Internships - types, hospitals, addresses and dates of service:

Type	Hospital and Address	Date

4. Residencies and other Graduate training - types, hospitals, addresses and dates:

Type	Hospital and Address	Date

LICENSURE

**** Please be advised, MCHC reserves the right to verify licensing and any past grievances that may have been filed against the medical license. This information is open to the public via each individual state's medical licensing board. This information is available for the past ten years.**

5. Licensure:

Type	State	Date Received	Last Renewal	Number	Exam/Reciprocity

6. If certified, give name of Board and date of certification: _____
 If not certified, do you contemplate certification? _____
 When do you believe you will be eligible? _____
 Give name of the Board of your choice: _____

7. If a graduate of a foreign medical school, have you taken the examination of the Education Council for Foreign Medical Graduates? _____ Date and Result? _____
 If not taken, do you plan to? _____ When? _____
 Temporary ECFMG Certificate No. _____ Dated _____
 Regular ECFMG Certificate No. _____ Dated _____

8. Hospital Appointments (List Chronologically appointments to hospital staffs, showing name of hospital, type of appointment: active, courtesy, etc, dates of service and privileges:

Type and Privilege	Hospital and Address	Date

9. Teaching Appointments:

Name and Address	Subject	Date

10. Military Service Assignments - If recently in military service, list assignments, with dates, etc:

Date Of Induction	Branch	Rank		Type of Duty
		Induction	Discharge	

11. (A) Solo Practice and/or Group Practice (list types of practice, location, and dates of practice in addition to training appointments already listed:

11. (B) Name and describe your present position if in other than solo or group practice: _____

REFERENCES

12. References: (Three professional and two personal) Professional references must be persons who have supervised your professional work or been associated with you professionally and who know you well. Personal references cannot be family members.

Name, Title and Address Telephone (if known)	During what years did he/she know you?	What was his/her relationship to you professionally (teacher, etc.)
1		
2		
3		
4		
5		

13. Availability: If employed, when would you be available? _____

May we contact your employer? _____

14. Length of employment desired (a minimum of three years will be expected, with the exception of locum tenens and summer students): _____

15. Minimum salary expected: _____ per year

ADDITIONAL INFORMATION

16. Have you ever had a license refused, revoked or suspended? _____

If your answer is yes, please provide details: _____

17. Are you now involved in malpractice litigation? _____

If your answer is yes, please provide details: _____

18: Do you now have professional liability insurance coverage? _____

Name of Carrier: _____

Expiration Date: _____

Please briefly state your philosophy of (a) healthcare and (b) rationale for seeking employment with Mountain Comprehensive Health Corporation:

CONTACT INFORMATION

Please list the name, address and telephone number of a person through whom you can always be reached:

AUTHORIZATION

** Please read the information below and sign as acknowledgement.

I authorize investigation of all matters contained in this application and agree that if in the judgement of the Company, any misrepresentation has been made by me herein or the results of such investigation are not satisfactory, any offer of employment made by the Company may be withdrawn. I understand that nothing in this application, or in any prior or subsequent written or oral statement, creates a contract of employment or any rights in nature of a contract. I agree and understand that if I am hired by the Company, my employment will be "at-will", for an indefinite period of time, and may be terminated at any time, with or without cause or notice, at the option of the Company or myself.

Printed Name of Applicant

Signature of Applicant

Date of Application