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
P.O. Box 40
Whitesburg, KY 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 profession 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. The information is open to the public via each individual state's medical licensure board. This information is available for the past ten years.**

5. Licensure:

Type	State	Date Received	Last Renewed	Number	Exam/Reciprocity

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

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

Name, Title, Address and Phone (if known)	During what years did he/she know you?	What was his/her relationship to you professionally?
1.		
2.		
[redacted]		
4.		
5.		

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

[redacted]

18. ~~Do you now have professional liability insurance coverage?~~

Name of Carrier:

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 judgment of the Company, any misrepresentation has been made by me herein or he 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 conduct. 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