



KOBOR

MedSearch, LLC

An Anesthesia Search Company

(706) 265-5045

(706) 265-5043

evenson@kobormedsearch.com

Dear Doctor:

Welcome to Kobor Med Search, LLC, a leader in quality Anesthesia locum tenens and permanent staffing since 1998.

To ensure that your application is processed as quickly as possible, please note the following:

- In order for us to complete our verification / referencing we must receive legible copies of all items listed on the next page. This is also what we will work from to complete your hospital applications, provider enrollment applications, etc. If you cannot provide a requested document please tell us why, and let us know if it will be forthcoming.**
- The following application must be completed, signed and dated. Please do not leave any areas blank. If a question is not applicable please mark N/A.**

Please return the completed application and credentials to us via email. If you have any questions regarding your application, please don't hesitate to contact me.

Thank you for allowing us the opportunity to work with you!

Sincerely,

Betty K Evenson

(706) 265-5045

(706) 265-5043 fax

evenson@kobormedsearch.com



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Please complete and return the enclosed application along with copies of the documents listed below:

- Current Curriculum Vitae (please include month and year with an explanation of any time gaps)
- Current copy of State License(s)
- Current copy of CPR Certification (many facilities require that these be through the AHA)
- Current copy of ACLS Certification (many facilities require that these be through the AHA)
- Current copy of PALS Certification (if applicable)
- Current copy of NRP Certification (if applicable) (course should be through the Amer Assoc of Ped)
- Certificates of Malpractice Insurance for the past ten years
- Current Controlled Substance Registration Certificate (if applicable)
- DEA Certificate(s)
- 4 prof references include name, address (hospital address is fine) email and phone number
- Copy of Medical School Diploma
- Copy of Residency Certificate
- Copy of Fellowship Certificate, if applicable
- Copy / Listing of CME's received
- Copy of State Driver's License with photo (must be color copy)
- Copy of Social Security Card
- Copy of NPI Notification Letter, Log-in & Password
- NPI – Username and Password (contact (800) 465-3203 to obtain)
- CAQH Log-in & Password – (contact (888) 599-1771 to obtain)
- ECFMG Certificate, if applicable
- Copy of current Visa or Alien Registration, if applicable
- Current Photo (cell phones are great – take a head shot selfie against a plain background and email it)
- Copy of DD214 - Military Discharge (if applicable)
- Case Logs – 2 years
- Copy of Physician Health Statement, if applicable
- Current PPD Test Results
- Current Flu Vaccination (if applicable)
- Current Covid Vaccination (if applicable)
- Current Immunization List (please use attached form and provide copies of all vaccination forms, etc.)
- Release and Authorization – attached to this email

I know it looks like an awful lot of paperwork. Once you complete the initial process, it is much easier the next time, as we will have copies of your credentials to forward to your future locum assignments.

IMMUNIZATION / HEALTH FORM

Name (Print): _____

Address: _____

Physical Exam	Date of Exam _____
	Results _____

Tuberculosis Testing	Date of Test _____
	Results _____

PPD (or Chest x-ray if history of +PPD)	Date of Test _____
	Results _____

Rubella and Rubeola Titer OR 2 MMR Vaccinations	Date of Test _____
	Results _____

Hepatitis B Immunization	Date of Tests _____
	Results _____

Immunity to Mumps	Date of Positive Mumps _____
	or Date of Mumps Vaccine _____

Flu Vaccination	Date _____
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*** Attach documentation / additional explanations as needed for above**

Information Completed By (Print): _____

Signature: _____

Date: _____

Vaccination information must be updated on an annual basis

KOBOR MED SEARCH, LLC
PO Box 1931 - Dawsonville, GA 30534
(706) 265-5045 / (706) 265-5043 (fax)
betty@kobormedsearch.com

Physician Application

Name of Applicant: _____ DO / MD

Former or Maiden Name: _____

Address: _____

City / State / Zip: _____

Telephone: (cell) _____ (other) _____

E-Mail: _____

Date of Birth: _____ Social Security Number: _____

City / County / State of Birth : _____

Are you a US Citizen? _____ If no, Citizenship: _____

Position Desired: _____ Locum Tenens? _____ Permanent? _____ Both? _____

Date Available: _____

Foreign Languages Spoken: _____

Geographical Preference: _____

Current Licensure: _____

Pending Licensure: _____

Medical School Attended: _____

Dates Attended: _____

Anesthesia Program Attended: _____

Dates Attended: _____

Program Director: _____

Phone Number of Director: _____

Are You Board Certified? _____ Are you board Eligible? _____

What month / year did you become Board Certified? _____ Board Certification #: _____

Health Status: Do you have any physical or mental condition, including chemical / substance dependency that would compromise your ability to practice as an Anesthesiologist or perform appropriate clinical duties?

Have you used drugs recreationally, or have you ever been treated for alcoholism, narcotic addiction or mental illness?

Do you need special accommodations to carry out your daily responsibilities as an Anesthesiologist?

*If you answered yes to any of the above questions, please provide details, on a separate sheet.

Malpractice Insurance Info:

Name of your current carrier: _____

Do you presently have occurrence coverage? _____

Did you purchase tail coverage from your present carrier? _____

Have you ever been a party in or been involved in any malpractice claim or suit? _____

When? _____

Do you have any knowledge of any occurrence or circumstance that is likely to result in a malpractice claim or suit against you? _____

*If you answered yes to any of the above Malpractice Insurance questions, please provide details, on a separate sheet.

Disciplinary Actions:

Have you even been the subject of any investigation by any private, state or federal health insurance program or other governmental agency? _____

Have you even been suspended from the Medicare / Medicaid Program? _____

Has your license to practice a Physician ever been denied, revoked, suspended or in any way limited?

Have you ever been censored by any committee of a state or county medical association with regard to ethics or fees? _____

Have your staff privileges ever been denied, suspended or in any way restricted at any facility? _____

Have you ever been the subject of a licensing board inquiry? _____

Have you ever been denied a state medical license? _____

Has any insurance carrier ever declined, canceled or refused to renew your professional liability insurance?

Have you ever been denied HMO, PPO, or other health plan participation? _____

Medicare # _____ Medicaid # _____

NPI Notification # _____ Please include a copy of your NPI letter

NPI Log-In _____ NPI Password _____

***IF YOU DON'T KNOW YOUR NPI LOG-IN / PASSWORD PLEASE call (800) 465-3203 TO OBTAIN**

Do you have a CAQH account? _____ CAQH Log-In Provider ID: _____

CAQH Username: _____ CAQH Password: _____

***IF YOU DON'T KNOW YOUR CAQH LOG-IN / PASSWORD PLEASE call (888) 599-1771 TO OBTAIN**

Have you ever voluntarily surrendered your medical license, staff privileges or consented to a limitation of the same pending a review or investigation? _____

Are there any other issues that should be disclosed that may have an adverse impact on your ability to deliver effective medical services? _____

*If you answered yes to any of the above Malpractice Insurance questions, please provide details, on a separate sheet.

Have you ever voluntarily surrendered your medical license, staff privileges or consented to a limitation of the same pending a review or investigation? _____

Are there any other issues that should be disclosed that may have an adverse impact on your ability to deliver effective medical services? _____

*If you answered yes to any of the above Malpractice Insurance questions, please provide details, on a separate sheet.

Professional References: (please list at least 4).

Please include name, address, phone number and **email** address. We will send an email with our standard reference request.

1. _____

2. _____

3. _____

4. _____

5. _____

Additional Education / Prior Employment:

Please attach a current CV with this application. If you do not have an updated CV please list pertinent dates, including education and employment, on a separate sheet.