

**Anesthesiologist Application for Employment**

Name \_\_\_\_\_  
(Last) (First) (Middle)

Social Security Number \_\_\_\_\_ Telephone \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Birth Date \_\_\_\_\_ Birth Place \_\_\_\_\_

Email address \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Education:**

College \_\_\_\_\_

Graduation Date \_\_\_\_\_ Degree \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**Medical School**

Name: \_\_\_\_\_

Graduation Date \_\_\_\_\_ Degree \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**Anesthesia Training/Residency**

Name: \_\_\_\_\_

Graduation Date \_\_\_\_\_ Certificate: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**Other Education / Fellowship Training:**

College / Location \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Major /Specialty \_\_\_\_\_ Years Completed \_\_\_\_\_ Degree \_\_\_\_\_  
(if applicable)

-----

**Professional Organization Memberships:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Licenses: (Submit copies of documents)**

State PA MD License Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

State \_\_\_\_\_ MD License Number \_\_\_\_\_ Expiration Date \_\_\_\_\_  
(if other)

**Physician Information: (Submit copies of documents)**

DEA Number: \_\_\_\_\_

NPI Number: \_\_\_\_\_

**Other Certifications / Training: (submit copies of these documents)**

BLS Expiration Date: \_\_\_\_\_ ACLS Expiration Date: \_\_\_\_\_

PALS Expiration Date: \_\_\_\_\_

Other Certifications: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Professional Liability Insurance: (submit copy of documents)**

Name of Carrier: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Limits of Liability: \_\_\_\_\_

Dates of policy: \_\_\_\_\_ until \_\_\_\_\_

A. Are you responsible for your Professional Liability Insurance Coverage or is it provided by your present employer/hospital? Self-insured \_\_\_\_\_ Employer insured \_\_\_\_\_

B. Has your professional liability insurance carrier and/or the amount of professional liability insurance changed since your last appointment? Yes \_\_\_\_\_ No \_\_\_\_\_

If the answer to any of the questions below is YES, please provide a full explanation of the details on a separate sheet and attach to this application. If the answer to #3 is YES, your explanation should include the following information: (a) date suit or claim was initiated; (b) brief description of the nature of the claim; and (c) current status, including the substance of the findings in each action that has been concluded and the amount of any final judgments or settlements made.

1. Have you been denied professional liability insurance or has your coverage been canceled or has a surcharge been imposed based on your claims experience? Yes \_\_\_\_\_ No \_\_\_\_\_

2. Has your present professional liability insurance carrier excluded any specific procedures from your insurance coverage? Yes \_\_\_\_\_ No \_\_\_\_\_

3. Have there been, or are there currently pending, any malpractice claims, suits, settlements, or arbitration proceedings involving your professional position? Yes \_\_\_\_\_ No \_\_\_\_\_

**Peer Recommendations:** Please furnish two letters of recommendation, one from your current department head.

**Continuing Education:** Please furnish copies of CEU's for past two years

**General Information:**

Have any of the following been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, or not renewed? Or have you voluntarily relinquished, withdrawn or failed to proceed with an application for any of the following in order to avoid an adverse action, for non-adverse reasons, or to preclude an investigation or while under investigation relating to professional conduct? If the answer to any of the following questions is YES, please provide full explanation, including resolutions of occurrence on a separate sheet and attach.

- A. License(s) for practice in any state Yes \_\_\_\_\_ No \_\_\_\_\_
- B. Other health related professional registration/license Yes \_\_\_\_\_ No \_\_\_\_\_
- C. Any other type of professional sanction Yes \_\_\_\_\_ No \_\_\_\_\_
- D. Have you been convicted of or pleaded no contest to any criminal charges (other than motor vehicle speeding violations) brought against you? Yes \_\_\_\_\_ No \_\_\_\_\_
- E. Have you been convicted of or pleaded no contest to a drug or alcohol related offence? Yes \_\_\_\_\_ No \_\_\_\_\_
- F. Have any disciplinary actions or investigations by any state licensing board been initiated against you? Yes \_\_\_\_\_ No \_\_\_\_\_

**Professional Anesthesia Experience: (most recent first)**

1. Employed by \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Facility: \_\_\_\_\_

Position \_\_\_\_\_ Period of Employment \_\_\_\_\_

2. Employed by \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Facility: \_\_\_\_\_

Position \_\_\_\_\_ Period of Employment \_\_\_\_\_

**Other Professional Experience:**

Employed by \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Position \_\_\_\_\_ Period of Employment \_\_\_\_\_

**Health Status:**

I am mentally and physically capable of performing the privileges, which I have requested. I consent to release of information necessary for the evaluation of my background, training, professional competence and ethical character. I affirm that the information included in this document is true to the best of my knowledge.

My last physical was \_\_\_\_\_ performed by \_\_\_\_\_

I attest that to the best of my knowledge, the information in this application has been answered correctly.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Important Note: Signing your name with your keyboard constitutes a legal replacement for your hand written signature. Please complete all applicable information prior to submission. Your failure to provide all information requested in this application may result in the denial or delay of your application

**Submit your saved application via email to [jobs@pasna.net](mailto:jobs@pasna.net)**