Advantage Anesthesia Group

Contact: Heather M. Murphy
13451 San Antonio Road
Tampa Bay, FL 34609-8733

Fax: (775) 665-5051 Phone: (561) 504-8595

Mail, Fax or Email completed documents to: AnesthesiaDoctors@gmail.com

Name: _____ Date: _____

Document Check List:
Please include the following documents with your AAG Application:
( ) Completed Application
( ) Copy of Current Curriculum Vitae
( ) Copy of signed and dated 'Attestation and Authorization' Release Form
( ) Copy of Florida Medical License and any other state Medical Licenses, if applicable.
( ) Copy of Diplomas, Certificates, Board Certification/Eligibility Letter
( ) Copy of your Federal D.E.A Certificate
( ) Copy of your Medical Malpractice Certificate
( ) Copy of BLS and ACLS Cards
( ) Copy of current PPD Non-Reactive Result or Chest X-ray Letter
( ) A clear, legible copy of your Driver License or other Government Issued Photo ID
( ) Copy of your 'Self Query' from the National Practitioner's Data Bank **www.NPDB.hrsa.gov**

Note: PLEASE PRINT LEGIBLY. Any 'yes' answers must be accompanied by an explanation. In cases of disciplinary actions, both past, present and/or pending, please provide support documentation and legal documentation. If there has been a settlement in your name, please provide the settlement amount, the name of insurance company and broker information. If more space is required to answer any section of this application, please attach your answer/s on a separate page. **Please answer all questions. If a question does not apply, please enter 'N/A'.**

Last Name _____ First _____ Middle_____
Birth Name _____
Home address_____ Apt. # _____
City/state/zip code _____
Best Phone # _____ Alternate Phone # _____
Email Address _____ Citizenship _____
Date of birth _____ Place of birth _____
Office address _____ Office Phone number _____
Suite ____ S.S. or Tax ID Name & FEIN_____
Driver License #_____ **(Provide a clear copy w/paperwork)** State: _____
Degree: M.D.____ D.O.____ Languages spoken:_____
Are you eligible to work in the United States? Yes ___ No ___

EMERGENCY CONTACT INFORMATION
Name _____ Phone # _____
Address _____ Relationship _____
City, State, Zip _____

HEALTH STATUS: Have you ever had, or do you now have any physical condition, chemical or other addiction, or any mental or emotional condition or disorder that may compromise your ability to safely and appropriately practice medicine and perform the duties of the position for which you are applying? Yes____ No _____

MILITARY STATUS

Have you served in the United States Military? No ___ Yes ___ From _____ to _____
If yes, which branch? _____
Type of discharge? _____

Primary Practice Specialty: _____

How much experience do you have in Office Based, Plastic Surgery Anesthesia? _____
Date you can begin working? Date: _____ Tentative or Firm? _____
Circle the days of the week you are free to work for position you are applying: M T W Th F
Are you interested in a: *Permanent*____ *LT*_____ *PT*_____ or *PRN* _____ position?

EDUCATION

Pre-Medical: _____
College/University _____
Degree _____
Honors _____
Date of graduation _____
Address _____
_____

MEDICAL EDUCATION

Medical School _____ Degree _____
Address _____
_____
Dates Attended _____to _____ Date of graduation _____

INTERNSHIP

Hospital/ Institution _____
Address _____
_____
Dates Attended _____to_____
Program Chairperson _____
Type of Internship _____

RESIDENCY

Hospital Institution _____
Address _____
_____
Dates Attended _____to_____
Type of Residency _____
Program Chairperson _____

CONTINUED EDUCATION

Fellowship(s) _____
Institution _____
Address _____
_____
Dates Attended _____to_____
Program Chairperson _____
Type of fellowship _____

Board Certification(s) _____
_____
Specialty/Board _____ Certification Date _____
Re-Certification Date _____
Board Eligibility Date _____

PROFESSIONAL ASSOCIATIONS and MEMBERSHIPS:

List all professional associations and/or memberships of which you are currently a member:
_____
_____
_____
_____

WORK HISTORY: Are you leaving or did you leave your most recent employer? Y or N
If yes, why? _____
_____
_____
_____

List employers in reverse chronological order, beginning with the most recent employer first. Please list all dates from medical school to present. If there are any gaps of time during medical school through your work history to date, please list the dates and reasons for any gaps in time on a separate sheet of paper.

Name of Institution: _____
Address _____
_____
Phone number _____
Dates Employed _____to_____ Position _____
_____

Name of Institution: _____
Address _____
_____
Phone number _____
Dates Employed _____to_____ Position _____
_____

Name of Institution: _____
Address _____
_____
Phone number _____
Dates Employed _____to _____ Position _____
_____

Name of Institution: _____
Address _____
_____
Phone number _____
Dates Employed _____to _____ Position _____

HOSPITAL AFFILIATIONS
List all hospital affiliations, in reverse chronological order, beginning with the most recent. If additional space is required, please include on a separate sheet of paper.

Name of Hospital: _____
Phone Number: _____
Address: _____
_____
Staff Category: _____ Dates _____to_____
_____

Name of Hospital: _____
Phone Number: _____
Address: _____
_____
Staff Category: _____ Dates _____to_____
_____

Name of Hospital: _____
Phone Number _____
Address: _____
_____
Staff Category: _____ Dates _____to_____
_____

Name of Hospital: _____
Phone Number _____
Address: _____
_____
Staff Category: _____ Dates _____to_____

LICENSES
Attach copies of all licenses. Please list any additional licenses on a separate sheet of paper. If a substance control number is required for any of the states listed above, attach copies with the license. List all current and past medical licenses.

State: License number: Issue Date: Expiration date:
_____
_____
_____

Date *****ACLS Certification Issued: _____ Expiration date: _____
Date *****BLS Certification Issued:_____ Expiration date:_____
DEA Registration Number: _____
Issue date: _____ Expiration date: _____

*****Must be issued through: The American Heart Association, American Safety and Health Institute, American Red Cross, Pacific Medical Training approved Basic Life Support course with didactic and skills components, or ACLS Certification Institute Basic Life Support course with didactic and skills components.

LICENSURE AND CLAIMS HISTORY

If your answer is 'Yes' please provide a detailed explanation on a separate sheet of paper.
1) Have you ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental, administrative agency, hospital or professional association? Yes____ No_____
2) Have you ever had any State professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes _____ No _____
3) Has hospital privileges and / or professional services ever been denied, revoked, suspended, refused, limited, placed on probation, or placed under any disciplinary action whatsoever? Yes _____ No ____
4) Have there been or are there any pending malpractice claims, judgments, suits, settlements, or notice of intent to commence action involving you and / or your medical practice? Yes ____ No ____
5) Have you ever been convicted of an act committed in violation of any law or ordinance other than a minor traffic violation? Yes ____ No ____
6) Do you have, or have you ever had any chemical dependency or have you ever been treated for any type of chemical dependency? Yes ____ No ____
7) Have you ever had any professional liability insurance company cancel, decline, refuse to renew, or accept only on special terms, their malpractice insurance? Yes ____ No ____

PROFESSIONAL REFERENCES: Please provide at least 5 physician references, of whom **at least 3 must be surgeons**, who have had clinical contact with you within the last 12 months and who are willing to and capable of assessing your professional skills.

Reference: _____Phone:_____
Address: _____
_____
Fax: _____ E-mail: _____

Reference: _____Phone:_____
Address: _____
_____
Fax: _____ E-mail: _____

Reference: _____Phone:_____
Address: _____
_____
Fax: _____ E-mail: _____

Reference: _____Phone:_____
Address: _____
_____
Fax: _____ E-mail: _____

Reference: _____Phone:_____
Address: _____
_____
Fax: _____ E-mail: _____

Advantage Anesthesia Group
Contact: Heather M. Murphy
13451 San Antonio Road
Tampa Bay, FL 34609-8733

Fax: (775) 665-5051 **Phone: (561) 504-8595**

www.Anesthesia-Doctors.com
Email: AnesthesiaDoctors@gmail.com

Re: _____ (Print your name)

Date of Birth: _____ FL Medical License #_____

ATTESTATION AND AUTHORIZATION

I certify that all the information submitted by me on this application is true and complete to the best of my knowledge. I authorize Advantage Anesthesia Group to release any information contained in this application to its Risk Management resource, credentialing/licensing agency, insurance companies, and medical facility clients.

I hereby authorize the disclosure by any institution (including but not limited to the Federation of State Medical Boards and State Licensing Boards) information regarding me, including my education, medical training, employment, skills, experience, fitness to practice medicine, character, work habits, job performance, certification, licensure, hospital staff or clinical privileges, DEA authorization and medical malpractice claims. The undersigned releases all providers of such information and/or opinions from any claims resulting from the disclosure to Advantage Anesthesia Group.

Printed Name: _____ Signature:_____ Date:_____

AUTHORIZATION AND WARRANTY

I authorize the release of all information from Medical Schools, Colleges, Universities, Medical Institutions, Hospitals, Clinics, Physicians, State Medical Boards, Medical Malpractice Carriers, All Government Agencies, References, and any other sources necessary to assist with my application process.

I understand that all information will be used to evaluate my professional qualifications.

Printed Name: _____ Signature:_____ Date:_____

Advantage Anesthesia Group
13451 San Antonio Road
Tampa Bay, Florida 34609-8733
www.Anesthesia-Doctors.com

Phone: 561-504-8595 Email: AnesthesiaDoctors@gmail.com Fax: 775-665-5051

CONFIDENTIALITY – NON-COMPETE AGREEMENT

I, _____, hereby agree and acknowledge that Advantage Anesthesia Group, Inc., (Company), formerly known as United Anesthesia Group, Inc. may introduce me and/or my credentials to their Providers, Clients and Prospective Clients for the purpose of conducting business, providing anesthesia service coverage and/or securing contracts for same.

I agree to keep all information regarding rates, agreements, compensation and any placement/s by Company confidential. I agree not to become engaged in business or activity with Company's Clients, Prospective Clients, Prospective Providers, or Providers of Company so as to compete or interfere directly or indirectly with Company without the consent of Company in writing, for a period of two (2) years from the date of introduction, or the date I no longer provide services for Company, whichever is latest.

I acknowledge that to do so would be a violation of this agreement which may be enforced by the Company through filing of injunction proceedings against me in the event that I breach this covenant. I agree to pay reasonable expenses, court costs and attorney's fees for myself and Company should I violate this agreement and legal action become necessary. In the event of any litigation arising out of or relating to this agreement, the parties stipulate the venue of any such action shall be in Hernando County, Florida.

Nothing contained in this agreement shall be construed as requiring the commission of any act contrary to law. Whenever there is any conflict between any provisions of this agreement and any present or future statute, law, ordinance or regulation contrary to which the parties have no legal right to contract, the latter shall prevail, but, in such event the provision of this agreement thus affected shall be curtailed and limited only to the extent necessary to bring it within the requirements of the law. In the event that any part, article, paragraph or clause of this agreement shall be held to be indefinite, invalid or otherwise unenforceable, the remainder of the agreement shall continue in full force and effect. If any tribunal or court of appropriate jurisdiction deems any provision hereof (other than for the payment of money) unreasonable, said tribunal or court may declare a reasonable modification hereof, and this agreement shall be valid and enforceable and the parties hereto agree to be bound by and perform the same as thus modified.

I HAVE READ THE FOREGOING AGREEMENT AND I HEREBY ACCEPT AND AGREE TO EACH AND ALL OF THE PROVISIONS, COVENANTS AND CONDITIONS THEREOF. I HEREBY ACKNOWLEDGE RECEIPT OF A COPY OF THIS AGREEMENT.

Signature:_____ Date:_____

Printed Name: _____ Witness:_____

ADVANTAGE ANESTHESIA GROUP

ANESTHESIA SKILLS SHEET

Name_____

DATE_____

Directions: Please use the proficiency scale below to indicate your level of experience with the following anesthesia skills.

PROFICIENCY SCALE:

0= Not trained or prefers not to perform.
1= Trained or limited recent experience.
2= Experienced or comfortable.
3= Very proficient, performs frequently, requires no assistance.

	Proficiency
General Anesthesia	
Balanced/Narcotic Technique	_____
Inhalation	_____
Ketamine	_____
MAC	_____
Total IV Anesthesia/Diprivan	_____
Regional Anesthesia	
Axillary	_____
Epidural-Monitoring	_____
Epidural-Placement	
General Surgery	_____
Labor & Delivery	_____
Intrathecal Narcotics	_____
IV Bier	_____
Ocular	_____
Pain Management	_____
Subarachnoid	
Monitoring	_____
Placement	_____
Other	_____
Other	_____
Certifications	**(Check)**
BLS	_____
ACLS	_____
PALS	_____
Pediatric General Anesthesia	
Ages 1-3	_____
Ages 4-12	_____
Ages under one	_____
Intensive Neonates	_____

Anesthesia Skills Sheet Cont'd.

Specialized Procedures

Double Lumen Tube Placement	_____
Electro-Shock Therapy	_____
Emergency Intubations	_____
Emergency OBs	_____
Fiberoptic Intubation	_____
LMA Placement	_____
Lumbar Puncture	_____
Major Vascular	_____
Multiple Trauma	_____
Nasal Intubation	_____
Neuro Surgery	_____
Neonatal Resuscitation	_____
Open Heart/By Pass	_____
Outpatient Surgery	_____
Thoracotomy	_____
Ventilator Management	_____

Invasive and Non-Invasive

A-Line Monitoring	_____
A-Line Placement	_____
Capnography Monitoring	_____
Cardiac Output	_____
CVP Line Monitoring	_____
CVP Line Placement	_____
Pulse Oximetry Monitoring	_____
Swan Ganz Monitoring	_____
Swan Ganz Placement	_____

Practice Settings	**(Check)**
20-100 Beds	_____
100-200 Beds	_____
200-400 Beds	_____
More than 400 Beds	_____
Outpatient Surgery Center	_____
Office Based Anesthesia	_____
Sole Practitioner	_____
Pediatric Hospital	_____
Burn Center	_____
OB	_____

Statement of Accuracy

I certify that all answers stated above are complete and correct.

Signed_____

Dated_____