

LOCUM TENENS APPLICATION FOR OSTEOPATHIC PHYSICIANS - \$200

1. Name _____ M ___ F ___
Address _____

Work Phone: _____ Home Phone: _____
Date of Birth: _____ Place of Birth: _____
Social Security Number: _____ DEA Number: _____

2. Affidavit

I hereby certify that the information supplied in this application is true and accurate and that the attached is a true photograph of me. I understand that any false answers may result in denial, suspension or revocation of my license to practice osteopathic medicine in Maine.

Applicant: **Sign full name in the presence of a notary public who must complete affidavit and affix notarial seal over a portion of your photo.**

Signed: _____

PLACE YOUR

Subscribed and sworn to before me on: _____

RECENT

Notary Signature: _____

PHOTO

My commission expires on: _____

HERE!!

3. Medical Licensure Information – Please list all states where you have EVER held a license. List state, license number and current status of license.

4. Medical Education – List the name and location of the osteopathic medical school you attended and the date of your graduation.

5. Specialty Information - Please list your specialty: _____

Are you Board Certified? Yes _____ No _____ AOA Board Certified in your field? _____

Name of specialty board: _____

Date of Certification: _____

6. Professional Training and Experience – List in chronological order all professional education and experience. Include all time periods from date of graduation from medical school to the present. Give full addresses with zip codes. Please use additional sheet if necessary.

From	To	Name of Hospital/Institution	Address	Nature of Experience

7. Personal Data – Have you ever had any of the following occurrences? Please answer all questions. If any of them are answered “yes”, you must supply full details on a separate sheet of paper and attach it to the application. If details are not provided, application will not be processed. Please circle yes or no.

- a. Disabling physical or mental illness(es) that resulted in any hospitalization or that prevented you from working or carrying out your usual daily responsibilities for more than 30 days? Yes No
- b. Arrest(s) or conviction(s) for anything other than minor traffic violations? Yes No
- c. Hospital restriction(s) or suspension(s), voluntary or otherwise? Yes No
- d. Disciplined by a professional society? Yes No
- e. Malpractice award(s), judgment(s) or settlement(s)? Yes No
- f. Are you currently involved in a malpractice claim or lawsuit? Yes No
- g. Treated for a problem with alcohol and/or any mind or mood-altering substance? Yes No
- h. State licensing boards notify you of a complaint or taken disciplinary action against you such as a fine or reprimand, voluntary or otherwise? Yes No
- i. Lost your medical malpractice insurance coverage for any reason? Yes No
- j. Restriction, suspension or loss of your DEA license? Yes No
- k. Currently under investigation by a hospital, licensing Board, Medicaid or Medicare or the DEA? Yes No

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past & present), business and professional associates (past & Present) and all governmental agencies and instrumentalities to release to this licensing Board any information, files or records required by the Board for its evaluation of my professional and ethical qualifications for licensure in the State of Maine.

Date: _____ Signature: _____

Full Name of Applicant (typed or handwritten): _____