



advanced care providers

Application

Phone: 715-661-0030
Fax: 323-375-3290
Email: mike@ACPstaff.com
ACPstaff.com

Last Name _____ First, Middle Name _____
Email address _____ Date Available _____
Specialty 1 _____ Specialty 2 _____
Previous legal names in the past _____
Where were you born City _____ State _____

Current Address Information

Street address _____
City _____ State / Zip Code _____
Phone (mobile) _____ Phone (home) _____

Emergency Contact:

Name of contact _____ Relationship _____
Street address _____
City _____ State _____
Zip Code _____ Phone (home) _____
Phone (work) _____ Phone (mobile) _____

Professional License / Certification:

National Certification							
Profession	<input type="checkbox"/>	Physician Assistant		<input type="checkbox"/>	Nurse Practitioner		
Certification	<input type="checkbox"/>	NCCPA		<input type="checkbox"/>	ANCC	<input type="checkbox"/>	Other
Cert Number							
Expiration							
State License							
License Number		State		Expiration			
License Number		State		Expiration			
License Number		State		Expiration			
License Number		State		Expiration			
License Number		State		Expiration			

Please provide a legible copy of ALL state licenses you hold, National certifications, and diplomas.

License / Certification / Courses:

Check all applicable certifications and enter expiration date:

<input type="checkbox"/>	Certification	Expiration	<input type="checkbox"/>	Certification	Expiration
<input type="checkbox"/>	BLS		<input type="checkbox"/>	ATLS	
<input type="checkbox"/>	ACLS		<input type="checkbox"/>	APLS	
<input type="checkbox"/>	PALS		<input type="checkbox"/>		

Please provide a copy of your current certifications listed above.

DEA License					
License Number		State		Expiration	
License Number		State		Expiration	
License Number		State		Expiration	
Controlled Substance Act		State		Expiration	
Controlled Substance Act		State		Expiration	
Social Security number			Required for verification		

Please provide a copy of your current DEA license.

Name: _____

Professional References:

Please name 3 references that may be contacted. Please list supervisors if possible.

Name	Title
Address & Phone	
How long have you known this person	
In what capacity?	
Name	Title
Address & Phone	
How long have you known this person	
In what capacity?	
Name	Title
Address & Phone	
How long have you known this person	
In what capacity?	

Education:

Name / Address			
Dates attended - Month/year			
Diplomas, degrees			
City		State	

Graduate School:

Name / Address			
Dates attended - Month/year			
Diplomas, degrees			
City		State	

Other School:

Name / Address			
Dates attended - Month/year			
Diplomas, degrees			
City		State	

Please provide copies of your professional education diplomas.

Additional Information:

Please answer all questions. Please give details and current status for any YES answers on a separate sheet and attach to this application.	YES	NO
Has your license or certification ever been investigated, restricted, suspended or denied?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been denied credentialing at any healthcare facility	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been convicted of a crime other than a minor traffic violation? (Including sex-related or child-abuse-related offenses.) Driving under the influence is not considered a minor traffic violation. Exceptions due to state employment law: Conviction(s) that have been sealed, expunged, eradicated, dismissed, or overturned, and California Health & Safety Code §§11357 (b) & (c), 11360(c), 11364, 11365, 11550 marijuana-related convictions over 2 years old, should not be revealed.	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been named as a defendant in a professional liability action?	<input type="checkbox"/>	<input type="checkbox"/>
Can you submit verification of your legal right to work in the U.S.? Please include copy of your current driver's license or state/fed issued ID.	<input type="checkbox"/>	<input type="checkbox"/>
Are you practicing in the USA on visa, Please specify the type of work visa:	<input type="checkbox"/>	<input type="checkbox"/>

Name: _____

Employment History:

Please indicate all of your employments from the time of your graduation to the present, relating to the profession you are practicing - beginning with your most current employer. Account for any gap in employment (> 1 month) that you did not practice in your profession. If more space is needed you may copy this page.

Are you employed now? yes no

Name of Institution		Start & Finish Dates (month & year)
Street Address		City, State and Zip code
Phone Number	Fax Number	Affiliation Status

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Phone Number	Fax Number	Affiliation Status

USE THIS PAGE TO LIST ADDITIONAL JOB LOCATIONS AS NEEDED.
 Be sure to explain all gaps in your practice history.

Name of Institution		Start & Finish Dates (month & year)
Street Address		City, State and Zip code
Phone Number	Fax Number	Affiliation Status

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Street Address		City, State and Zip code
Phone Number	Fax Number	Affiliation Status

I attest that I am the applicant and the information provided in this application is complete and accurate, to the best of my knowledge. Providing incomplete or inaccurate information may result in disqualification from the program, and may be a violation of state law(s) that could result in civil penalties. The Company is authorized to obtain information from my current and previous employers, and to release information in support of my application (application, references, background search results, etc.) to the Company's client institutions. The Company may also share information regarding applicant's employment with its affiliates and appropriate governmental or licensing entities; and send me employment opportunity-related information at fax numbers or email addresses that I provide. I understand that the Company, certain states and/or Client institutions may require criminal background checks, and I consent to such checks. Prior to conducting any background checks that qualify as consumer or investigative consumer reports, I will be provided, and will return, separate disclosure and acknowledgement forms as required by the Company.

Notice of Applicant's Rights

You may review your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy and/or applicable state laws. If there are discrepancies in the information received during the process, you will be notified and allowed an opportunity to add information to your application.

Confirmation Signature and Date

I hereby certify that all the information on this application for is complete, true and accurate. I further agree to update this information as necessary so that it remains complete, true and accurate while my application is being processed.

Name: _____
(please print or type)

Signature: _____ Date: _____

If submitting online, typing your initials in this box constitutes your confirmation signature.

→ ←

Documents needed for credentialing

Current CV	Please include
Current State Licenses	All states and should be current
Current RN license if you are a NP	For NPs only – required to practice
Current National License	Based on your profession
DEA License	If your state requires Controlled Substance Act Certificate be sure to include
School Diplomas	Needed by facility to submit to insurance providers
Drivers License or Gov't issued ID	Need for background verification. Send a digital picture rather than faxing
Photo	Please email this.
References	3 required at most facilities for credentialing. At least one from a supervising physician, others by MD/DO/PA or NP
Malpractice claim history	If you have had a claim against you – forward the claim/suit information addendum
Certifications in courses you have taken	Included all current course certifications. Examples: BLS, ACLS, PALS, ATLS, APLS, CALS, etc.
CME log for current recert. cycle	Copy of CME credit courses you have taken
Immunization titers	MMR, Varicella, Hep B (need copy of the actual lab results document).
Immunization records	Many locations now require proof of Tdap and Influenza during Flu season.
TB test	Test within the last year is required. PPD or QTB Contact us if you have had positive test in the past.
Military form DD214 if discharged	Include form DD214 if you have been discharged from the services.

More information can be found on our web site or you can call us for further information on documents needed and why.

Your information is secure. We will contact you for approval prior to sending credential documents to any healthcare facility.

BACKGROUND INFORMATION DISCLOSURE (BID) INSTRUCTIONS

The Background Information Disclosure form (F-82064) gathers information as required by the Wisconsin Caregiver Background Check Law to help employers and governmental regulatory agencies make employment, contract, residency, and regulatory decisions. Complete and return the entire form and attach explanations as specified by employer or governmental regulatory agency.

CAREGIVER BACKGROUND CHECK LAW

In accordance with the provisions of Chapters 48.685 and 50.065, Wis. Stats., for persons who have been convicted of certain acts, crimes, or offenses:

1. The Department of Health Services (DHS) may not license, certify, or register the person or entity (Note: Employers and Care Providers are referred to as "entities");
2. A county agency may not certify a child care or license a foster or treatment foster home;
3. A child placing agency may not license a foster or treatment foster home or contract with an adoptive parent applicant for a child adoption;
4. A school board may not contract with a licensed child care provider; and
5. An entity may not employ, contract with or, permit persons to reside at the entity.

A list of barred crimes and offenses requiring rehabilitation review is available from the regulatory agencies or through the Internet at <http://dhs.wisconsin.gov/caregiver/StatutesINDEX.HTM>.

THE CAREGIVER LAW COVERS THE FOLLOWING EMPLOYERS / CARE PROVIDERS (Referred to as "Entities"):

Programs Regulated under Chapter 48, Wis. Stats.	Treatment Foster Care, Family Child Care Centers, Group Child Care Centers, Residential Care Centers for Children and Youth, Child Placing Agencies, Day Camps for Children, Family Foster Homes for Children, Group Homes for Children, Shelter Care Facilities for Children, and Certified Family Child Care.
Programs Regulated under Chapters 50, 51, and 146, Wis. Stats.	Emergency Mental Health Service Programs, Mental Health Day Treatment Services for Children, Community Mental Health, Developmental Disabilities, AODA Services, Community Support Programs, Community Based Residential Facilities, 3-4 Bed Adult Family Homes, Residential Care Apartment Complexes, Ambulance Service Providers, Hospitals, Rural Medical Centers, Hospices, Nursing Homes, Facilities for the Developmentally Disabled, and Home Health Agencies – including those that provide personal care services.
Others	Child Care Providers contracted through Local School Boards

THE CAREGIVER LAW COVERS THE FOLLOWING PERSONS:

- Anyone employed by or contracting with a covered entity who has access to the clients served, except if the access is infrequent or sporadic and service is not directly related to care of the client.
- Anyone who is a Child Care Provider who contracts with a School Board under Wisconsin Statute 120.13 (14).
- Anyone who lives on the premises of a covered entity and is 10 years old or over, but is not a client ("nonclient resident").
- Anyone who is licensed by DHS.
- Anyone who has a foster home licensed by DHS.
- Anyone certified by DHS.
- Anyone who is a Child Care Provider certified by a county department.
- Anyone registered by DHS.
- Anyone who is a board member or corporate officer who has access to the clients served.

FAIR EMPLOYMENT ACT

Wisconsin's Fair Employment Law, Chapters 111.31 - 111.395, Wis. Stats., prohibits discrimination because of a criminal record or pending charge; however, it is not discrimination to decline to hire or license a person based on the person's arrest or conviction record if the arrest or conviction is substantially related to the circumstances of the particular job or licensed activity.

PERSONALLY IDENTIFIABLE INFORMATION

This information is used to obtain relevant data as required by the provisions set forth by the Wisconsin Caregiver Background Check Law. Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches. For example, the Department of Justice uses social security numbers, names, gender, race, and date of birth to prevent incorrect matches of persons with criminal convictions. The Department of Health Services' Caregiver Misconduct Registry uses social security numbers as one identifier to prevent incorrect matches of persons with findings of abuse or neglect of a client or misappropriation of a client's property.

BACKGROUND INFORMATION DISCLOSURE (BID)

Completion of this form is required under the provisions of Chapters 48.685 and 50.065, Wis. Stats. Failure to comply may result in a denial or revocation of your license, certification, or registration; or denial or termination of your employment or contract. Refer to the instructions (F-82064A) on page 1 for additional information. Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.

PLEASE PRINT YOUR ANSWERS.

Check the box that applies to you.

- | | |
|---|---|
| <input type="checkbox"/> Employee / Contractor (including new applicant)
<input type="checkbox"/> Applicant for a license or certification or registration (including continuation or renewal) | <input type="checkbox"/> Household member / lives on premises - but not a client
<input type="checkbox"/> Other – Specify: |
|---|---|

NOTE: If you are an owner, operator, board member, or non client resident of a Division of Quality Assurance (DQA) regulated facility, complete the BID, F-82064, and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

Name – (First and Middle)	Name – (Last)	Position Title (Complete only if you are a prospective employee or contractor, or a current employee or contractor.)		
Any Other Names By Which You Have Been Known (Including Maiden Name)		Birth Date	Gender (M / F)	Race
Address Street, City, State, ZIP Code			Social Security Number(s)	
Business Name and Address - Employer or Care Provider (Entity)				

SECTION A - ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
1. Do you have any criminal charges pending against you or were you ever convicted of any crime anywhere, including in federal, state, local, military and tribal courts? > If Yes, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located. You may be asked to supply additional information including a certified copy of the judgement of conviction, a copy of the criminal complaint, or any other relevant court or police documents.		
2. Were you ever found to be (adjudicated) delinquent by a court of law on or after your 10 th birthday for a crime or offense? (NOTE: A response to this question is only required for group and family day care centers for children and day camps for children.) > If Yes, list each crime, when and where it happened, and the location of the court (city and state). You may be asked to supply additional information including a certified copy of the delinquency petition, the delinquency adjudication, or any other relevant court or police documents.		
3. Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? A response is required if the box below is checked: <input type="checkbox"/> (Only employers and regulatory agencies entitled to obtain this information per sec. 48.981(7) are authorized to, and should, check this box.) > If Yes, explain, including when and where it happened.		
4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? > If Yes, explain, including when and where it happened.		

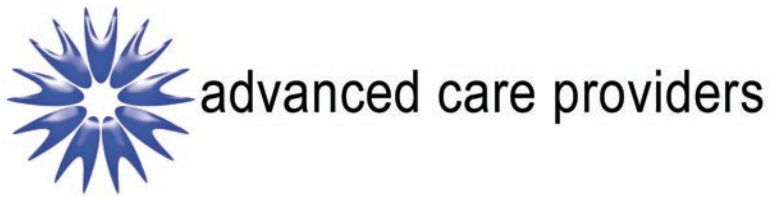
(continued on next page)

SECTION A (continued)	YES	NO
5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? > If Yes, explain, including when and where it happened.		
6. Has any government or regulatory agency (other than the police) ever found that you abused an elderly person? > If Yes, explain, including when and where it happened.		
7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? > If Yes, explain, including credential name, limitations or restrictions, and time period.		
SECTION B – OTHER REQUIRED INFORMATION	YES	NO
1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? > If Yes, explain, including when and where it happened.		
2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? > If Yes, explain, including when and where it happened and the reason.		
3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? > If yes, indicate the year of discharge: _____ > Attach a copy of your DD214 if you were discharged within the last 3 years.		
4. Have you resided outside of Wisconsin in the last 3 years? > If Yes, list each state and the dates you lived there.		
5. Have you had a caregiver background check done within the last 4 years? > If Yes, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.		
6. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS designated tribe? > If Yes, list the review date and the review result. You may be asked to provide a copy of the review decision.		

A "NO" answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.

I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a forfeiture of up to \$1,000.00 and other sanctions as provided in DHS 12.05 (4), Wis. Adm. Code.

SIGNATURE	Date Signed
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Disclosure and Release

In connection with my application for consideration of staffing assignments (including contract for services) with Advanced Care Providers (ACP) to Health Care Facilities (Entities), I understand that a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment/contractor purposes will be conducted. I understand that it is my responsibility to produce adequate information for a complete evaluation of my qualifications. I understand that the scope of the consumer report/investigative consumer report may include, but is not limited to, the following areas: Verification of social security number; current and previous residences; employment history including personnel files; education including transcripts; character references; criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; birth records; motor vehicle records to include traffic citations and registration; past malpractice insurance coverage and related judgments I may have been involved in; and any other public records; or to conduct interviews with third parties relative to my character, general reputation, or work ethics and performance.

I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me to ACP or its agents and Entities. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources.

I hereby release ACP, the Entities, the Social Security Administration, and its agents, officials, representatives, or assigned agencies, including officers, employees, or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may, at any time, result to me, my heirs, family, or associates because of compliance with this authorization and request to release. You may contact me as indicated below.

I hereby authorize procurement of consumer report(s)/investigative consumer report(s). If hired or contracted, this authorization shall remain on file and shall serve as ongoing authorization for ACP to procure consumer report(s)/investigative consumer report(s) at any time during my employment (or contract) period and to provide information to medical facilities I currently am credentialed at or facilities I agree to apply for credentialing and privileges. I understand I have the right to revoke the authorization at any time, provided I do so in writing.

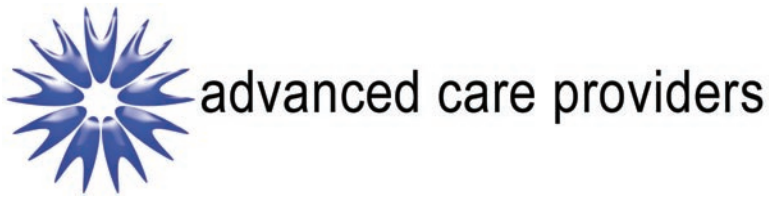
By applying for the affiliations requested, I accept the following conditions regardless of whether or not I am granted appointment or privileges, and intend to be legally bound thereby. These conditions shall remain in effect for the duration of any term of any and all appointments I may be granted.

To the fullest extent permitted by law, prior to and throughout any period of my affiliations with the Entities, I extend absolute immunity to, release from any and all liability, and agree not to sue ACP, the credentialing service, the Entities, their authorized representatives, and/or 3rd parties who provide information for any matter relating to my application for appointment or my qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken, or received by ACP, the credentialing service, the Entities, their authorized representatives, and/or 3rd parties in the course of credentialing and peer review including but not limited to: applications for appointment or clinical privileges, including interim or temporary privileges; periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges; proceedings for suspension or reduction of clinical privileges for denial or revocation of reappointment, or any other disciplinary action; hearings and appellate reviews; quality assessment/improvement activities; utilization reviews; other Entity committee activities; matters or inquiries concerning professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or behavior; and any other matter that might directly or indirectly disrupt the orderly operation of the Entities or any other hospital or health care entity.

I authorize ACP, the Entities and their authorized representatives to consult with any 3rd party who may have information bearing on my professional qualification (credentials), clinical competence, character, judgment, mental or emotional stability, physical condition, ethics, or behavior, bearing on my qualifications for appointment to the medical staff and/or Network (such information is referred to herein as "Credentialing Information"). This authorization includes the right to inspect and to obtain any and all documents, recommendations, reports, statements, or disclosures relating to such Credentialing Information. I expressly authorize said 3rd parties to release Credentialing Information to the Entities, and their authorized representatives upon request. I also expressly authorize the Entities to release Credentialing Information to any medical clinic or other Entity at which I am employed, seeking employment or contracted with as a health care provider.

Name (print): _____ Date: _____

Signature: _____



Health Information Privacy & Consent Confidentiality Statement

With the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), personally identifiable healthcare records came under a new and heightened level of confidentiality. In the regular course of business, Advanced Care Providers (ACP) interacts and communicates directly with candidates who may share their personally identifiable information. In turn, we collect, store and process the information electronically and/or manually. With the belief that it is a person's right to have their personal information kept private, ACP conducts business with respect for and in compliance with all applicable health information privacy laws, including but not limited to HIPAA. We respect our legal obligation to implement privacy procedures and technical security measures to keep your personal information private and secure. As we are obligated to give you notice of our privacy practices, the statement of policies and protocols which follows describes how our staff may use and disclose your medical information and how you may get access to this information and relative accounting. After reviewing the information carefully, please complete, sign, and date this form, then return it via fax or mail to the addresses listed at the end of this statement.

For the purpose of this document and for employment through ACP, your "health information" includes the following items that we request on behalf of our facility clients:

- Annual physician's or health record statement
- Documentation used to prove immunity to measles, mumps, and rubella [laboratory titers or records of MMR injection(s)]
- Documentation used to prove immunity to Varicella [laboratory titer, record of Varivax immunization, or immune by history statement]
- Documentation used to prove immunity to HBV [laboratory titer or record of HBV immunization series] or a declination statement thereof
- Annual tuberculosis screening [PPD test results or chest x-ray reading]
- Pre-placement drug screening [conducted by ACP or contracted facility]

Generally, we cannot use your health information or disclose it outside of our office without your written permission. The written permission comes from your completed consent form. We ask you to sign the consent form allowing us to use and disclose your health information for purposes of submittal to client facilities, of assignment to job openings at client facilities, and continued employment through ACP at client facilities. For example, your health information may be sent via fax or email to a client representative either for submittal consideration or to confirm placement. Facility representatives [HR managers, nursing officers, unit managers or medical staff services] will review your health information to evaluate whether or not you meet their standard immunization requirements set forth for temporary staff. An ACP representative will advise you of any necessary medical documentation for placement. Any variation from the facility standard may delay or cancel an assignment. We may refuse to place you if you do not sign the consent form. At times, client facilities may request further documentation than the above defined "health information" of a candidate's health and immunization records to comply with state or local regulations. At those instances, an ACP representative will advise you of the requirements and request your consent for that additional information.

The law gives you many rights regarding your health information. You may request photocopies of your health information, an amendment to any incorrect or incomplete information, additional copies of this notice, or a list of the disclosures we have made of your health information. ACP reserves the right to change this statement at any time in compliance with and as allowed by law. If we make any changes, the new policies and protocols will apply to your health information that we already have as well as to such information that we may generate or request in the future. We will send out notices of any changes via mail and post them in our office and on our website www.ACPstaff.com. If you should have any questions concerning ACP privacy practices or wish to access or correct private information collected from you, please contact our HIPAA Privacy Officer via mail, phone, fax, or email: MAIL: PO Box 972, Minocqua, WI 54548 PHONE: 715-661-0030 FAX: 323-375-3290 EMAIL: mike@ACPstaff.com

I confirm that I have read, understand, and consent to the policies and protocols regarding disclosure and transmission of information as outlined in this statement regarding my health information.

Name (print): _____ Date: _____

Signature: _____