Providence
Medical Clinic of Kingsport

Medical Provider Application

The information provided on this application will be classified as confidential and will be kept on file at Providence Medical Clinic. The information will only be used to contact PMC providers regarding clinic operations and for verification of professional status. At no time will the information be released to sources outside Providence Medical Clinic.

Personal Information

Name: ____ Degree:____________________

Date of Birt :____________________

Social Security Number: ________________________

Home Address: ____

____

Phone ________________________ (cell)

________________________ (home)

________________________ (emergency contact)

Email Address: ____

(Email is the primary method used by PMC for contacting volunteers regarding scheduling and general clinic announcements. Please alert the clinical coordinator if you would like to receive communication by another method.)

Professional Information

Practice Name: ____

Practice Address: ____

Practice Phone: ____

Local Hospital Admitting Privilege :________________________________

Medical School: ____

(International medical graduates, please indicate
ECFMG Certificate Number________________________Exp. date________

Post-graduate Training: 1) ____

Type of training________________________________

2) ____

Type of training________________________________

3) ____

Type of training________________________________

Name: ____

Licenses, Certifications

Professional License: Indicate all states you hold current or inactive license(s).

STATE	LICENSE NUMBER	EXPIRATION DATE

Please submit a copy of your current Tennessee license with this application.

Please provide DEA registration for each state in which you currently practice and prescribe medications.

STATE	DEA NUMBER	EXPIRATION DATE

BOARD CERTIFICATION/SPECIALTY

Names of specialty boards by which you are certified:

Name of Board: ____

Date Certified: __________________________Expiration Date: ___________________________

Name of Board: ____

Date Certified: __________________________Expiration Date: ___________________________

Reference

Please provide the name of a medical provider who may be contacted for a peer reference regarding your professional competency and ethical character.

Reference Name: ____

Reference Email or Phone: ____

* In submitting this application to serve as a volunteer medical provider at Providence Medical Clinic of Kingsport, I agree to treat all patient information, medical and spiritual, as confidential. I also agree to support the clinic vision statement: *Providence Medical Clinic of Kingsport offering compassionate medical and spiritual care for the underserved residents of the Greater Kingsport area.*

Signed: ____Date:__________________________

Received by :____Date:__________________________

05/22/2010