

WAPITI MEDICAL GROUP

Subcontractor Application

Name _____ MD or DO _____ Date _____

Address _____ SS# _____

City _____ Phone# _____

State _____ Zip _____ Email _____

Personal Corporation _____ Tax ID # _____

Medical School _____ Dates _____

Residency _____ Dates _____

Boards _____ Dates _____

DEA # _____ State DEA # _____

Malpractice Suits filed _____

Will you have your own malpractice insurance? _____ (If yes, please include a copy of the certificate).

State Licenses _____

Will you need help filing for a state license? _____ Which state(s)? _____

Any License revocation or restriction _____

How many hours are you interested in working each month? _____

Are you interested in working at a number of different sites or primarily at a single location? If a single site, do you have a particular site you are interested in? _____

PROFESSIONAL REFERENCES:

1. Name: _____
Address: _____
Phone: _____

3. Name: _____
Address: _____
Phone: _____

2. Name: _____
Address: _____
Phone: _____