HealthWorks
Where health happens

2508 E. Fox Farm Road, 1-1A
Cheyenne, WY 82007
Phone: (307) 635-3618
Fax: (307) 635-1442
www.WYhealthworks.org

Application for Employment – Clinician

(HealthWorks does not discriminate based on color, creed, religion, national origin, gender, age, disability, sexual orientation or any other status protected by law.)

Position applying for:

☐ Dentist ☐ Medical Assistant
☐ Nurse Practitioner ☐ Pharmacist ☐ Pharmacy Technician ☐ Physician
☐ Physician Assistant ☐ Registered Nurse ☐ Other: _____

Please accurately complete the entire application.
No action will be taken on applications with missing information.

I. PERSONAL

Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____ (Please PRINT clearly.)
Have you worked or attended school under any other names? ☐ YES ☐ NO
If YES, please list them: _____
Place of Birth: _____ Date of Birth: _____
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic ☐ Ethnic Black
☐ Decline to Answer ☐ Unavailable

Are you a citizen of the United States? ☐ YES ☐ NO
If no - if you are hired can you furnish proof of eligibility to work in the United States? ☐ YES ☐ NO

Are you licensed to practice in the State of Wyoming? ☐ YES ☐ NO
If no, have you applied for a temporary Wyoming license? ☐ YES ☐ NO

EMERGENCY CONTACT:

Name: _____ Phone: _____

How did you learn about the position? _____
If hired, when could you begin employment at HealthWorks? _____

Type of employment you are seeking (check all that apply):
☐ Full Time ☐ Part Time ☐ Temporary ☐ Independent Contract

II. EDUCATION

	Name & City, State	Dates	Diploma / Degree / Certificate	Subject / Specialty
Professional Education				
College / University				
High School / GED				
Other Training (type and certification – i.e. CPR, ACLS, RT, MT, ASCP)				

III. EMPLOYMENT HISTORY

Please provide information on your last three (3) employed positions – list the most recent first. Attach additional sheets if necessary.

TO AVOID DELAYS IN PROCESSING YOUR APPLICATION, PLEASE ACCOUNT FOR ALL PERIODS OF EMPLOYMENT AS A HEALTH PROFESSIONAL -
EXPLAIN ANY GAPS IN EMPLOYMENT DATES

Employer Name: _____ Phone: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Supervisor: _____ Employment Status: ☐ Full Time ☐ Part Time ☐ Temp
Start Date: End Date: Ending Salary:

Employer Name: _____ Phone: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Supervisor: _____ Employment Status: ☐ Full Time ☐ Part Time ☐ Temp
Start Date: End Date: Ending Salary:

Employer Name: _____ Phone: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Supervisor: _____ Employment Status: ☐ Full Time ☐ Part Time ☐ Temp
Start Date: End Date: Ending Salary:

IV. BACKGROUND INFORMATION

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A DETAILED EXPLANATION OF THE EVENT(S) REFERRED TO IN YOUR AFFIRMATIVE RESPONSE, PLEASE ALSO PROVIDE COMPLETE AND LEGIBLE DOCUMENTATION REGARDING THE EVENT(S). Your application will not be processed until the HealthWorks Board of Directors receives such explanation and documentation and, if appropriate, investigates such matters.

These definitions apply to the following questions.

1. "Ability to practice as an allied health professional" includes all of the following:
    a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgment and to learn and keep abreast of medical developments; and
    b. The ability to communicate those judgments and medical information to physician supervisors, patients and other health care providers, with or without the use of aids and devices such as voice amplifiers; and
    c. The physical capacity to perform medical tasks as delegated by the physician supervisor such as physical examinations and surgical procedures, with or without the use of aids or devices, such as corrective lenses and hearing aids.
2. "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes in accordance with the prescriber's direction as well as those used illegally.
3. "Medical condition" includes mental/emotional or psychological conditions or disorders such as but not limited to orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disability, HIV disease, tuberculosis, drug addiction and alcoholism.

V. QUESTIONS	**YES**	**NO**
A. Have you ever been convicted of, pled guilty to, pled nolo contendere to, or are charges pending against you for any crime including felonies, misdemeanors, municipal ordinances and/or any military code of justice violation, including driving under the influence of any intoxicating substance but not including non-moving traffic violations which did not involve alcohol or substance impairment? Include the following information in your attached written explanation: a. The name and location of the court where you were charged and the docket number of your case; b. the offense(s) to which you pled or were found guilty; c. all the terms of the sentence imposed; d. whether you have completed the sentence; e. the date the sentence was imposed; and f. if applicable, the name, address, and telephone number of your probation officer. Attach a copy of the sentencing order and any orders indicating that the sentence has been completed.	☐	☐

	YES	NO
B. Do you have any medical condition which, in any way, impairs or limits, or might impair or limit, your ability to safely and skillfully assist in the practice of medicine? Include the following information in your attached written explanation: a. the diagnosis: b. the treatment plan and prognosis; c. the name, address, and telephone number of your treating physician; d. the manner in which condition impairs your ability to safely and competently practice medicine; e. any restriction or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and f. how you intend to accommodate such condition in the practice you intend to conduct in the State of Wyoming. <u>Attach the most recent medical records and/or written report from your treating physician describing the diagnosis, the current treatment being undertaken, a prognosis, and any limitations arising from such condition.</u>	☐	☐
	YES	**NO**
C. Within the past five (5) years have you sought evaluation of, treatment for, or been admitted (including outpatient admissions) by any provider and/or any facility for the treatment of mental or emotional disability or substance use disorder? IF YOU HAVE A FULLY EXECUTED CONTRACT WITH THE WYOMING PROFESSIONAL ASSISTANCE PROGRAM YOU MAY ANSWER "NO" TO THIS QUESTION. Include the following information in your attached written explanation: a. the circumstances and diagnosis; b. the treatment you are undergoing and prognosis; c. the name, address, and telephone number of your treating physician; d. the manner in which this condition impairs your ability to safely and competently assist in the practice of medicine; e. any restriction or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and f. how you intend to accommodate such condition in the practice you intend to conduct in the State of Wyoming. <u>Attach the most recent medical records and/or a written report from your treating physician that describes the diagnosis, the current treatment being undertaken, a prognosis, and any limitations arising from such condition.</u>	☐	☐
	YES	**NO**
D. Within the past five (5) years have you been evaluated, diagnosed, or treated in any manner for any substance use disorder including but not limited to alcohol, tranquilizers, sedatives, psychoactive medications, cocaine, marijuana, opiates, benzodiazepines, or any other narcotic or potentially addictive substance?	☐	☐

IF YOU HAVE A FULLY EXECUTED CONTRACT WITH THE WYOMING PROFESSIONAL ASSISTANCE PROGRAM YOU MAY ANSWER "NO" TO THIS QUESTION. Include the following information in your attached written explanation: a. the treatment; b. the name, address, and telephone number of your treating physician; c. any restrictions or conditions imposed upon your practice by any licensing agency or health care facility due to such condition; and d. how you intend to accommodate such condition in the practice you intend to conduct in the State of Wyoming. <u>Attach any agreement between you, any professional assistance organization, AA or other rehabilitation and/or monitoring group.</u>		
	YES	**NO**
E. Within the past five (5) years have you been reprimanded, demoted, disciplined, cautioned, placed on probation or terminated by any employer, education institution or training program for any reason? Include the following information in your attached written explanation: a. the circumstances leading to the action; b. the effective date of the action; c. the name, title, address, and telephone number of the person/s taking such action; and d. resolution and/or current status of such action. <u>Attach records of the action including final orders and/or findings</u>	☐	☐
	YES	**NO**
F. In the past year have you been, or are you now, under investigation or have any adverse charges or complaints been filed against you by any medical licensing board, local, state, federal or military professional or disciplinary body or any hospital privileging or credentialing body, grievance committee or any other medical group, including medical societies and specialty boards?	☐	☐
	YES	**NO**
G. Have you ever been denied licensure or privileges by any licensing board, hospital, medical facility, professional society, specialty board or medical body? Include the following information in your attached written explanation: a. the basis of denial; b. the name, address, and telephone number of the entity which denied your application; and c. the date the denial was issued. <u>Attach all records of the application and denial process including final orders and/or findings.</u>	☐	☐

	YES	NO
H. Have you ever withdrawn an application for privileges or licensure in any jurisdiction?	☐	☐
Include the following information in your attached written explanation: a. the name, address, and telephone number of the entity to which you had applied; b. the license, privileges or membership applied for; c. the date you withdrew the application; d. the reason for the withdrawal; and e. whether the withdrawal was permitted by the entity in lieu of a denial of the application. <u>Attach all records of the application and withdrawal process including final orders and or/findings.</u>		
VI. <u>LIABILITY INFORMATION</u>	**YES**	**NO**
A. In the last (5) years have any professional liability claims been filed against you?	☐	☐
If your answer to this question is "Yes" please indicate how many and provide a complete written explanation for each claim including: a. the name and location of the court where the action was filed and the case docket number; b. the allegations of the claim against you; c. the manner in which the claim was resolved; d. the amount, if any, paid to the claimant by you and/or your insurance carrier; and e. the date the claim was resolved. <u>Attach a copy of any final judgment, order or settlement documents that relate to the disposition of the claims against you.</u>		
	YES	**NO**
B. Has a professional liability insurance carrier ever terminated your coverage?	☐	☐
Include the following information in your attached written explanation: a. the name, address, and telephone number of the company which terminated coverage; b. the basis for termination; and c. the date of the termination. <u>Attach a copy of any correspondence or other documentation which relates to the denial of coverage.</u>		

VII. REFERENCES

Please PRINT clearly – this information is important for credentialing purposes.

Name: _____ Phone: _____
Title / Relationship to You: Length of Time Known:
Mailing Address: _____
City / State / Zip: _____ Email Address: _____

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Name: _____ Phone: _____
Title / Relationship to You: _____ Length of Time Known: _____
Mailing Address: _____
City / State / Zip: _____ Email Address: _____

I _____ attest, under penalty of perjury, that the information I have provided is true and correct to the best of my knowledge.

Signed: _____ Date: _____