DCO Provider Application

Part 1: Applicant Information

Full Name: _____ Date: _____
Last (both) First M.I.

Address: _____
Street Address Apartment/Unit #

_____
City State ZIP Code

Mailing Address: _____
Street Address Apartment/Unit #

_____
City State ZIP Code

Phone: _____ Email _____

Date Available: _____ Social Security No.: _____ DOB: _____

Position Applied for: _____

Are you a citizen of the United States? YES ☐ NO ☐ If no, are you authorized to work in Puerto Rico or the U.S.? YES ☐ NO ☐

Have you ever worked for this company? YES ☐ NO ☐ If yes, when? _____

Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, explain: _____

Part 2: Education

Nursing School: _____ Address: _____

From: _____ (mm/yy) To: _____ (mm/yy) Did you graduate? YES ☐ NO ☐ Degree:: _____

Post Graduate : _____ Address: _____

From: _____ (mm/yy) To: _____ (mm/yy) Did you graduate? YES ☐ NO ☐ Degree: _____

Post Graduate : _____ Address: _____

From: _____ (mm/yy) To: _____ (mm/yy) Did you graduate? YES ☐ NO ☐ Degree: _____

Part 3: Professional ID / Licenses / Certifications

Board Registration ____________________ # ____________________ **Expiration Date:** ____________________

State License & number: ____________________ # ____________________ **Expiration Date:** ____________________

CMS # ____________________ NPI # ____________________

Part 4: Professional Liability Insurance

Current Carrier: ____________________ Policy number: ____________________

Policy Limits _________/ ___________ Effective Dates (mm/dd/yy) From: ___________ To _________

Part 5: Work History

Company: ____________________ Phone: ____________________

Address: ____________________ Supervisor: ____________________

Job Title: ____________________

Responsibilities: ____________________

From: ____________ (mm/yy) To: ____________ (mm/yy) Reason for Leaving: ____________________

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: ____________________ Phone: ____________________

Address: ____________________ Supervisor: ____________________

Job Title: ____________________

Responsibilities: ____________________

From: ____________ (mm/yy) To: ____________ (mm/yy) Reason for Leaving: ____________________

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: ____________________ Phone: ____________________

Address: ____________________ Supervisor: ____________________

Job Title: ____________________

Responsibilities: ____________________

From: ____________ (mm/yy) To: ____________ (mm/yy) Reason for Leaving: ____________________

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Part 6: References

Please list three professional references.

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Part 7: Attestation

Please answer the fallowing questions, provider an explanation for all "Yes" responses using the attached from (from A) sign date the attestation and each additional sheet.

	Yes	No
1. Has your license to practice in any state of the US or Commonwealth of Puerto Rico been suspended, restricted, revoked, or voluntarily surrendered, been subject to a consent order or has probation ever been invoked?	☐	☐
2. Have any of your board certifications ever been suspended or revoked?	☐	☐
3. Have you ever been sanctioned by or suspended from the Medicare or Medicaid program?	☐	☐
4. Do you have any inability to perform the essential functions of the position, with or without accommodation?	☐	☐
5. Have you ever been convicted for the use of illegal or controlled substances?	☐	☐
6. Are you currently engaged in the illegal use of drugs?	☐	☐
7. Have you ever been convicted of, pled guilty to, or pled no contest to any felony?	☐	☐
8. Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, pharmacy, diagnostic treatment center, hospital or a business that provides ancillary health services, medical equipment or supplies? If YES, please provide the following information:	☐	☐

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Disclaimer: Our Company does not discriminate in its process for conducting credentialing, preliminary background checks and in the submission of documentation to the assigned Health Plan.

Signature: _____ Date: _____

Gap Explanation Page: