

***Community Action Agency of Columbiana County***

7880 Lincole Place

Lisbon, OH 44432

1-330-424-7221 (Phone)

1-330-424-3731 (FAX)

**INFORMATION RELEASE FORM**

I hereby authorize Community Action Agency, 7880 Lincole Place, Lisbon, OH 44432 to investigate any and all information on this application. I consent to and authorize any other third party to provide such information; including, but not limited to evaluations, recommendations, work histories, to Community Action Agency. I further release from any claim or liability all persons who furnish such information.

---

**Signature and Date**

**Community Action Agency of Columbiana County**

7880 Lincole Place  
Lisbon, OH 44432

Name \_\_\_\_\_ MD/DO/DDS/DMD/PhD/LPCC/LISW

Address \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Phone (Work) \_\_\_\_\_

Present Position \_\_\_\_\_

When are you available to begin? \_\_\_\_\_

Name, Address and Phone Number of someone who will always know your forwarding address

**PREMEDICAL EDUCATION**

School of Graduation \_\_\_\_\_

Dates Attended \_\_\_\_\_

Degree \_\_\_\_\_

**MEDICAL/DENTAL EDUCATION**

School of Graduation \_\_\_\_\_

Dates Attended \_\_\_\_\_ Degree \_\_\_\_\_

**INTERNSHIP**

Hospital \_\_\_\_\_

City & State \_\_\_\_\_ Dates \_\_\_\_\_

Type of Internship \_\_\_\_\_

**RESIDENCY**

Hospital \_\_\_\_\_

City & State \_\_\_\_\_ Dates \_\_\_\_\_

Type of Internship \_\_\_\_\_

Board Eligible \_\_\_\_\_ Board Certified \_\_\_\_\_ Date \_\_\_\_\_

**ADDITIONAL TRAINING AND/OR EXPERIENCE**

(Please indicate complete data from end of training program to present, or attach separate letter of explanation)

BLS Certified \_\_\_\_\_ ACLS Certified \_\_\_\_\_ ATLS Certified \_\_\_\_\_

**PROFESSIONAL PRACTICE HISTORY**

Summarize professional practice associations for the past ten (10) years in chronological order beginning with your most recent practice. Include all private practices, clinics, HMO's, military experience, and any other practice associations in which you have been employed, had privileges or practiced on the full-time or part-time basis.

Current Practice \_\_\_\_\_

Address \_\_\_\_\_

Clinical Department \_\_\_\_\_

Inclusive Dates \_\_\_\_\_

Reason for Termination \_\_\_\_\_

Salary: \_\_\_\_\_

Current Practice \_\_\_\_\_

Address \_\_\_\_\_

Clinical Department \_\_\_\_\_

Inclusive Dates \_\_\_\_\_

Reason for Termination \_\_\_\_\_

Salary: \_\_\_\_\_

Previous Practice \_\_\_\_\_

Address \_\_\_\_\_

Clinical Department \_\_\_\_\_

Inclusive Dates \_\_\_\_\_

Reason for Termination \_\_\_\_\_

Salary: \_\_\_\_\_

Previous Practice \_\_\_\_\_

Address \_\_\_\_\_

Clinical Department \_\_\_\_\_

Inclusive Dates \_\_\_\_\_

Reason for Termination \_\_\_\_\_

Salary: \_\_\_\_\_

**LICENSURE** (Please attach or forward a copy of your Ohio Medical/Dental License and DEA certificate).

Flex Exam \_\_\_\_\_ National Boards \_\_\_\_\_ ECFMG \_\_\_\_\_

State \_\_\_\_\_ License No. \_\_\_\_\_ Exp. Date \_\_\_\_\_

State \_\_\_\_\_ License No. \_\_\_\_\_ Exp. Date \_\_\_\_\_

State \_\_\_\_\_ License No. \_\_\_\_\_ Exp. Date \_\_\_\_\_

Federal DEA No. \_\_\_\_\_ Exp. Date \_\_\_\_\_

**REFERENCES:** Please provide the names of three (3) professional references from training programs and/or current associates that we may contact:

Name \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_ Dates of association \_\_\_\_\_

His/her position at time of your association \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_ Dates of association \_\_\_\_\_

His/her position at time of your association \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_ Dates of association \_\_\_\_\_

His/her position at time of your association \_\_\_\_\_

**PROFESSIONAL LIABILITY**

Please circle Yes or No. Explain "yes" responses below.

1. Yes No Has membership in any professional association or society ever been revoked or refused?
2. Yes No Has any hospital suspended, restricted, or refused your staff privileges?
3. Yes No Have you ever voluntarily surrendered or had a state license to practice medicine refused, suspended, or revoked?
4. Yes No Have you ever voluntarily surrendered or had a narcotics license refused, suspended, or revoked?
5. Yes No Have you ever been treated for alcoholism, narcotic addiction, or mental illness?
6. Yes No Have you ever been convicted of a felony?
7. Yes No Have you ever suffered from, or been treated for, any chronic illness or physical defect?

- 8. Yes No Have you ever had any professional liability insurance refused, cancelled, or non-renewed?
- 9. Yes No Have you ever had a grievance filed against you with your County or State Medical Society?
- 10. Yes No Have you ever been named in a malpractice claim or lawsuit, either pending or closed?

Explanations:

I certify that the information in this application is true and correct to the best of my knowledge. I further understand that intentional falsification herein will subject me to removal from, and consideration of, the position or dismissal subsequent to employment. I attest that I have no physical or emotional problems that would inhibit my ability to perform any duties with regards to the privileges to be requested.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**NOTICE:** Please attach your release statement, medical license, DEA certificate, and board certification to this application.

In order to perform a criminal background check as well as a check of the National Practitioner’s Database, your Social Security Number and Date of Birth are required. Please submit both along with this application.