

EXCHANGE MEDICAL PLACEMENT, LLC

Exchange Medical Placement, LLC (EMP) is an organization which assists in the recruitment and retention of health professionals throughout the United States of America. EMP is an information clearinghouse, referral and liaison service, not a hiring entity.

There is a fee for placement assistance.

PROVIDER INFORMATION FORM

INSTRUCTIONS

Please type or use black ink to complete this form. PHOTOCOPIES OF PAGES TWO AND THREE OF THIS FORM AND YOUR NARRATIVE STATEMENT MAY BE FORWARDED TO INTERESTED PARTIES, INCLUDING PROSPECTIVE EMPLOYERS. A resume may be submitted, in addition to or in lieu of this form. If you wish to provide more details, please attach additional sheets.

Always notify EMP of any changes in name, address, telephone number or availability.

NARRATIVE STATEMENT

Please attach a narrative statement describing your practice interests, community preferences, personal goals, recreational interests and any other information that would be pertinent to your selection of a practice opportunity in the United States, including your specific attraction(s) to a state and your reasons for desiring to practice there. In addition, please reference any or all associations with professional organizations, special awards, honors and/or capabilities which would highlight your experience and qualifications.

I learned about EMP from one of the following sources:
(Please check at least one source.)

- Home page/e-mail
- Professional journal
- EMP billboard
- Colleague
- Training program
- Rural Health News
- Professional association
- Board of licensure
- Conference
- Newspaper
- Radio/television
- Other _____

Social Security Number:

_____-_____-_____

Disclosure of Social Security Number is voluntary and is solicited only to provide positive identification.

PROVIDER TYPE: _____ **MD** _____ **DO** _____ **Nurse** _____ **Dentist**

PERSONAL INFORMATION

Name _____
(first) (middle) (last)

Home Address _____
(street) (city) (state) (zip code)

Telephone _____
(work) (home) (best time & place to call)

EDUCATIONAL BACKGROUND

Professional School _____
(name) (address) (year completed)

Internship _____
(name) (address) (year completed)

Residency _____
(name) (address) (year completed)

Fellowship _____
(name) (address) (year completed)

SPECIALTY TRAINING (EXPERIENCE)

_____ Family Practice	_____ Yrs	_____ Pediatrics	_____ Yrs
_____ General Practice	_____ Yrs	_____ Psychiatry	_____ Yrs
_____ Internal Medicine	_____ Yrs	_____ Surgery	_____ Yrs
_____ OB/GYN	_____ Yrs	_____ Other/Sub-Spec.	_____ Yrs.

Have you attempted/passed the following examinations:

National Board? Yes___ No___ Regional Board? Yes___ No___ CGFNS? Yes___ No___

State Board Yes___ No___ FLEX? Yes___ No___ ECFMG? Yes___ No___

American Board Certification? Yes___ No___ Residency program completed _____

Specialty _____

WORK HISTORY

Please provide a brief work history, listing last employer/practice first. Use additional paper or refer to curriculum vitae, as needed. _____

State(s) in which licenses(s) held: _____ Applied for: _____

DESCRIPTION OF POSITION DESIRED:

Size of community which most attracts you: (X = consider, XX = prefer)

- Rural (under 5,000)
- Small town (5,000-10,000)
- Medium town (10,000-25,000)
- Urban area (over 25,000)
- Indian reservation
- Specific area _____

Please indicate any preference for: Climate _____
 Geographical area(s) _____
 Leisure activities _____

Type(s) of practice in which you are interested: (X = consider, XX = prefer)

- Solo
- Emergency
- Associate/Group/Partner
- Institution
- Managed care
- Institution
- Public Health
- Community-based primary care
- Salary/Guarantee
- Migrant Health
- Practice incentives
- Indian Health
- Fee-for-service
- Administration/Education
- Hospital privileges desired

Are you aware of any circumstances which would restrict your ability to practice in the state of New Mexico?
 Yes No
 If yes, please attach explanation.

- Full Time Part Time Willing to accept call
- Locum Tenens
- Other (please specify) _____

What are your immediate financial expectations? _____

Do you have any state or federal service obligation? Yes No
 If yes, please describe: _____

Do you desire assistance with existing tuition debt? Yes No

Date(s) available: Interview _____
 Work _____

CONFIDENTIAL INFORMATION

Provision of the information requested below should be considered voluntary. It will be used for statistical purposes and to assist in the recruitment processes of this agency.

Date of birth: _____ Place of birth: _____

Citizenship/Visa Status: _____

Language skills/cross-cultural experience: _____

