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Doctor Application Form

- Please Specify:
- Anesthesiologist
 - Pediatrician
 - Radiologist
 - Urologist
 - Urogynecologist
 - Other _____

PERSONAL INFORMATION

Name: _____ Application Date: _____

Preferred Address for IVUmed Correspondence: _____

City: _____ State: _____ Zip/Postal code: _____ Country: _____

Phone (daytime): _____ Phone (evening): _____

Phone (mobile): _____ Fax: _____

Email Address: _____

Passport Number: _____ Citizenship: _____

Name of Spouse/Significant Other (if applicable): _____

Preferred Type of Workshop: General Incontinence Pediatric Stones

Languages Spoken: _____

Emergency Contact Names, Phone Numbers and Addresses (please list two):

1. Name: _____ Phone: _____

Address: _____

2. Name: _____ Phone: _____

Address: _____

PROFESSIONAL INFORMATION

Current Position: _____

Medical School of Graduation: _____ Dates Attended: _____

Residency Program: _____ Date Completed: _____

Program Director: _____

Fellowship Program (if applicable): _____ Date Completed: _____

Program Director: _____

Work-Related References, Phone Numbers and Addresses: *(please list two who can attest to your specific medical abilities and have worked with you in the last two years)*

1. _____

2. _____

Board Certified: Yes No Specialty: _____ Where taken: _____ Date: _____

Board Eligible: Yes No Specialty: _____ Where taken: _____ Date: _____

DEA Registration Number (if applicable): _____

Current Medical License Number: _____ State: _____ Date issued: _____

Current Experience *(please indicate which types of patients/programs with which you have had experience in the last five years):*

Check all that apply: Pediatric (0-6 years old) Pediatric (7-14 years old) Adult (over 14 years old)

Please describe any previous experience traveling or working in developing countries: _____

Please answer the following questions:

Yes No Are you now or have you ever been involved in any litigation, lawsuits, claims, or arbitration, or are you now involved in any threatened litigation or claim related to your professional activities?

Yes No Have judgments or settlements been made against you in professional liability cases or are you involved in any pending litigation or denied liability insurance at standard rates?

Yes No Have you ever been denied liability insurance?

- Yes No Has your membership or renewal thereof in any medical organization ever been revoked, suspended, diminished, or denied?
- Yes No Have your privileges in any hospital ever been suspended, diminished, revoked, denied or not renewed?
- Yes No Have you ever been charged with any crime other than minor traffic violations?
- Yes No Has your license in any jurisdiction ever been limited, suspended, or revoked?
- Yes No Has your federal DEA registration ever been limited, suspended, or revoked?
- Yes No Have you ever been subject to any disciplinary proceeding or action by any employer, hospital, or other entity or institution with respect to your professional activities or behavior?
- Yes No Have you ever received treatment, voluntarily or involuntarily for alcoholism or drug abuse, mental illness or psychiatric problems?
- Yes No Do you have any current or past health problems or conditions that would impact or limit your ability to practice medicine in a developing country?

If you answered yes to any questions, please provide a brief explanation: _____

I certify that the information on this application is true to the best of my knowledge. I authorize all persons and institutions to disclose to and share with IVUmed opinions and information regarding me, including but not limited to, information contained in this application and my skills, experience, fitness to practice medicine, character, work habits, and performance. I authorize IVUmed to release information contained in this application or obtained by IVUmed pursuant to the authorization contained in this paragraph to IVUmed's Board of Trustees, committee members and staff. I waive any claims I might otherwise have against IVUmed resulting from IVUmed obtaining or releasing information as authorized by this paragraph.

Signature: _____ Date: _____

Print Name: _____

DOCUMENT CHECKLIST

Please include the following items (preferably via regular mail or email):

- Curriculum Vitae including explanation of any time gaps within the last five years
- Two letters of recommendation (*one must be from the head of department where you practice*)
- One page personal statement, including any health issues and your current type of practice
- Copy of current medical license
- Copy of medical school diploma
- Copy of DEA (*if applicable*)
- Copy of CPR/BLS currency (*if applicable*)
- Copy of PALS currency (*if applicable*)
- Copy of current board certification (*if applicable*)
- Copy of current passport (*please do not fax; please send copy via regular mail or a scanned copy by e-mail*)
- Signed IVUmed Release form
- Tax-deductible usd \$50 application processing fee (*non-refundable*)