DUKE MEDICINEPHYSICIAN QUESTIONNAIRE

Name:						
Specialty:						
Mailing Addr	ress:					
City:			State:		Zip:	
Email addres	ss:					
Home Phone:			Cell Phone:			
Are you a U	S Citizen or a Lawful Pern	Yes	□No			
If No, Visa S	Status:					
States of Licensure: (past and present)						
ANSWERS TO THE FOLLOWING QUESTIONS ARE REQUIRED FOR CONSIDERATION FOR EMPLOYMENT:						
Has your license to practice your profession in any jurise surrendered, limited, suspended or revoked?			sdiction ever be	een [Yes	☐ No
Have your privileges at any hospital been suspended, di revoked or not renewed?			diminished,	[Yes	☐ No
Do you have any malpractice claims pending or have ar claims ever been settled against you?			ny malpractice	. [Yes	☐ No
	it or claim involving your o you were not specifically i		[Yes	□ No	
Have you ev or investigat	nding in resear	rch [Yes	□ No		
Have you ever been investigated or prosecuted for any leadicaid fraud allegations?			Medicare or	[Yes	□ No
If you answered yes to any of these questions, please furnish additional information on a separate sheet. Material omissions or misrepresentations relating to the information requested above may result in withdrawal of any offer of employment or later termination of employment.						
Date:	Date: Signature of Applicant:					
E	By typing my name on this	s form, I certify tha	at all informatio	on is corre	ct.	
Optional:						
Gender: Male Female	Ethnicity: Non-Hispanic/Latino Hispanic/Latino	Race: American Indian/. Asian Black Native Hawaiian/.]]]	☐ White ☐ More than on ☐ Unknown Rad	

Individuals with disabilities who anticipate requiring assistance during the application process may contact the Office for Disability Management Services at 919-668-6213. TTY 919-668-1329

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