Chiropractic
Staffing Solutions

CONTACT SHEET

NAME: _____

TEL: _____

E-MAIL: _____

PROFESSIONAL DESIGNATION(S) (DC, MD, etc.): _____

PROFESSIONAL LICENSES HELD (States/Designations):_____

_____

YEAR GRADUATED (Chiropractic): _____

PROFESSIONAL LIABILITY (Malpractice) CARRIER: Y N

If YES, Name: _____ Tel: _____

HAVE YOU EVER WORKED AS A LOCUM DOCTOR, ASSOCIATE, or INTERN?

Y N IF YES, When/Where: _____

ZIP code where you reside? _____

DO YOU HAVE TRANSPORTATION? Y N

ARE YOU ABLE TO WORK ANYWHERE IN THE VALLEY (PHOENIX)? _____

ARE YOU ABLE TO WORK OUT OF TOWN (Within AZ)? _____

WHAT IS YOUR FAVORITE COLOR? _____

WHAT WAS YOUR FAVORITE SUBJECT IN SCHOOL (Chiro)? _____

HAVE YOU EVER DENIED CARE TO A PATIENT FOR ANY REASON? Y N

PLEASE SCAN/EMAIL
Or
FAX THIS SHEET TO THE NUMBER OR ADDRESS BELOW

BLACKSTONE HEALTH ASSOCIATES, PC 480-244-1830 (T) 480-556-6670 (F)
chirostaffsolutions@me.com (Email)