

APPLICATION FOR BASE STATION PHYSICIAN

CHECK ONE:

NEW _____ FULL TIME PRACTICE E.M.
*RENEWAL _____ E.M. RESIDENT
_____ CHILDREN'S MERCY RESIDENT

***(IF RENEWING, ONLY INDICATE CHANGES TO INFORMATION IN LAST 2 YEARS)**

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ E-MAIL (OPTIONAL) _____

EMPLOYER _____

EMPLOYER PHONE NO. _____

JOB TITLE _____

MISSOURI MEDICAL LICENSE NUMBER _____

DESCRIBE FORMAL TRAINING AND LICENSES. INCLUDE DATES AND
SCHOOLS: _____

EMERGENCY MEDICINE BOARD CERTIFIED? _____ DATE _____

EMERGENCY MEDICINE BOARD ELIGIBLE? _____ DATE _____

**THIS IS TO CERTIFY THAT ALL STATEMENTS MADE ON THIS APPLICATION
ARE TRUE TO THE BEST OF MY KNOWLEDGE. I ACKNOWLEDGE AND
CONSENT TO THE RELEASE OF ALL DOCUMENTS REQUIRED FOR
EVALUATION OF THIS APPLICATION TO THE APPROPRIATE KANSAS CITY,
MISSOURI HEALTH DEPARTMENT OFFICIALS.**

SIGNATURE OF APPLICANT _____

DATE _____

Please fax or email to James McElroy at (816) 513-6294 or james_mcelroy@kcmo.org