Physician Information Application

Please print and fill in the information requested.
Return it to us by

Mail: Kona Community Hospital ATTN: Kathleen Rokavec, MD
79-1019 Haukapila St., Kealakekua, HI 96750
Email: krokavec@hhsc.org
or Fax: 808-322-4488

I am requesting information about working for, at or with (check as many as apply):

- ❒ Kona Community Hospital
- ❒ Kohala Hospital
- ❒ Alii Health
- ❒ The Hospitalist Program
- ❒ I am seeking information on private practice and would like the names of other groups or physicians who may be seeking colleagues, associates or partners.

❒ I am ❒ I am not - represented by a physician employment or placement agency.

Name: ______________________________ Degree: ______________

Specialty: ____

Office Address/State/Zip: ________________________________

____

Home Address/State/Zip: _________________________________

____

Preferred telephone number: ______________________________

e-mail address: ____

Name of schools/hospitals with dates attended:

College: ____

Medical School: ____

Internship: ____

Residency: ____

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Post Graduate Training/Fellowship: _________________________

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I am a citizen of ❒ USA ❒ Other: ________________ ❒ I have a J-1 Visa

I am Board ❐ Certified or ❐ Eligible in ______________________

Date of certification: ______________________

Current position: ______________________

Current hospital affiliations: ______________________

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I am licensed to practice medicine in the following states: ______________________

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My current medical liability carrier is: ______________________

I wish to leave my present position because: ______________________

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I wish to move to Hawaii Island because: ______________________

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If I find a suitable job in Kona, I would expect to move to Kona (when?): ________

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Below, please add any additional information or mention any questions you may have about your application: ______________________

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