



First and Last Name:

Date:

Position: Primary Care Physician – Fort Polk, LA

Please fill out the following questionnaire and submit with your resume:

1. Please list your Doctoral Degree (must be from an accredited institution), name of institution, and year of graduation.
2. Do you have a DEA Certification? Please state the date of expiration.
3. Do you have a PALS Certification? Please state the date of expiration.
4. Do you have an AHA Certification? Please state the date of expiration.
5. Do you have an ACLS Certification? Please state the date of expiration.
6. Do you have an ATLS Certification? Please state the date of expiration.
7. Do you have a Medical License? If so, in which state?