GRADUATE MEDICAL EDUCATION EMPLOYMENT APPLICATION

Please Print or Type

Last Name:

First Name:

Middle Name:

Preferred Start Date: (MM/YYYY)

Contact Address:

Permanent Address:

Home Phone Number:	Preferred Phone ☐
Work Phone Number:	Preferred Phone ☐
Cell Phone Number:	Preferred Phone ☐
Email:	
National Provider Identifier (NPI) Number:	
Date of Birth (MM/DD/YYYY):	
Place of Birth:	
Country of Citizenship:	
For Foreign Nationals:	Current Visa Type: Select Requested Visa Type: Select
Optional:	
Ethnicity:	
Race:	

Medical Licensure

Board Certified?	☐ YES ☐ NO
If yes, which Board:	
If no, do you plan to be?	☐ YES ☐ NO
If yes, which Board and when?	
Ever Named in a Malpractice Suit?	☐ YES ☐ NO
State Medical License?	☐ YES ☐ NO
If yes, specify state, number, expiration date:	
Are you a diplomate of the National Board of Medical Examiners (NBME)?	☐ YES ☐ NO
Have you successfully completed the Federation Licensing Examination (FLEX)?	☐ YES ☐ NO

Educational Commission for Foreign Medical Graduates Certification

Are you certified by the ECFMG?	☐ YES ☐ NO
If yes, ECFMG Number and date (MM/YYYY):	

Note: A copy of your ECFMG certificate is required for credentialing purposes.

Education (list all graduate and undergraduate schools; non-medical education only)

Education	Institution & Location	Dates Attended (MM/YYYY – MM/YYYY)	Degree	Degree Date (MM/YYYY)	Field of Study
☐ Graduate ☐ Undergraduate					
☐ Graduate ☐ Undergraduate					
☐ Graduate ☐ Undergraduate					

Medical Education

Institution & Location	Dates Attended (MM/YYYY – MM/YYYY)	Degree	Degree Date (MM/YYYY)

Current / Prior Post-Graduate Medical Training

Specialty / Experience	Institution & Location	Program Director	Dates Attended (MM/YYYY – MM/YYYY)	Years of Training

Previous Fellowships

Name of Fellowship	Institution & Location	Dates Attended (MM/YYYY – MM/YYYY)

Student/Faculty Committees (Curriculum Committees, Admissions Committees, etc.)

Committee	Institution & Location	Dates (MM/YYYY – MM/YYYY)	Duties

Work Experience (list any laboratory, research, or teaching assistant positions held)

Position	Hospital / Practice Name	City / State / Zip	Dates (MM/YYYY – MM/YYYY)

Please check any of the following government positions you may have held:

	Location	Dates (MM/YYYY – MM/YYYY)
☐ Military		
☐ National Health Service Corps		
☐ U.S. Public Health Service		
☐ Peace Corps		
☐ Other (Specify)		

Briefly describe the nature of the experiences you have checked which you feel are especially pertinent to this fellowship

Publications (enclose copies of those which you feel are most relevant)

Achievements (List up to four awards, honors, scholarships, etc. in order of perceived importance)

Name of Award	Award Citation	Institution	Date

Other Awards & Accomplishments

Research Experience & Area(s) of Interest

References (all references must send letters to the Project Director. One must be the Program Director of your most recent clinical training program.)

Name	Title	Address

If public service is of interest to you, please indicate which area(s) is most appealing

Please describe how your clinical experiences influenced your decision to apply for the General Pediatrics Academic Fellowship program. Use only the space provided:

Objectives for this Fellowship (Please limit your response to two pages and submit as an attachment to this application)

State the reason for your interest in the General Pediatrics Academic Fellowship Program. The Statement must describe your career goals, your research interests, and how these can be accomplished by acceptance into in the General Pediatrics Academic Fellowship Program. You may want to explain how past experiences influenced your decision to apply and mention special areas of interest. *Make sure your name appears on the attachment.*

If the answer to any of the questions below is "Yes," provide a full explanation in the space provided at the end of this form.
If you are a Ph.D. candidate, you need not complete this section.

1.	Have you ever been reported to the National Practitioner Data Bank, Healthcare Integrity and/or Protection Data Bank?	☐ YES ☐ NO
2.	Has your employment, medical staff appointment, panel participation, affiliation or clinical privileges ever been voluntarily or involuntarily suspended, diminished, revoked, refused or limited in any hospital, health care facility or managed care organization, IPA or PPO including to avoid disciplinary action for reasons related to professional competence or conduct?	☐ YES ☐ NO
3.	Has your license to practice your profession in any jurisdiction ever been limited, restricted, suspended, revoked, denied or subject to probationary conditions?	☐ YES ☐ NO
4.	Have you ever voluntarily or involuntarily relinquished your license to practice your profession in any state?	☐ YES ☐ NO
5.	Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (including Medicare, Medicaid or a managed care organization)?	☐ YES ☐ NO
6.	Has your narcotics registration certificate ever been voluntarily or involuntarily limited, restricted, denied renewal, suspended or revoked?	☐ YES ☐ NO
7.	Have you ever been denied membership, membership renewal or been subject to any professional review, censure or reprimand in any medical organization or professional society – local, state or national?	☐ YES ☐ NO
8.	Have you ever been subject to disciplinary action by a state agency or professional body (i.e., Medical Society, IPRO, OPMC)?	☐ YES ☐ NO
9.	Has your specialty board certification or qualification ever been voluntarily or involuntarily denied, revoked, relinquished, not renewed, suspended or reduced?	☐ YES ☐ NO
10.	Do you have any pending misconduct charges against you in this state or any other state?	☐ YES ☐ NO
11.	Have you ever been convicted of a misdemeanor or felony in any jurisdiction?	☐ YES ☐ NO
12.	Are you presently or have you ever been subject to any suspension, revocation, discontinuance, limitation, restriction, monitoring or probationary proceedings?	☐ YES ☐ NO
13.	Have you ever been cited for violation of patient rights as set forth by the Federal Law and/or NYS Department of Health or any other state department of health?	☐ YES ☐ NO
14.	Has your professional liability insurance coverage ever been surcharged, suspended or terminated by action of any insurance company?	☐ YES ☐ NO
15.	Has your professional liability insurance coverage ever been denied or not renewed by action of any insurance company?	☐ YES ☐ NO
16.	Has your present professional liability insurance carrier excluded any specific procedures from your coverage? If "Yes," list the procedure(s), the date(s) the exclusion(s) commenced in the space below.	☐ YES ☐ NO
17.	Have any professional liability suits been filed against you which are currently pending in this or any other state?	☐ YES ☐ NO
18.	Have any professional liability judgments and/or settlements ever been made against you or on your behalf?	☐ YES ☐ NO

If “Yes” to any of the above questions, please explain:

If “Yes,” list the procedure(s) the date(s) the exclusion(s) commenced in the space below. (Question 16)

Attestation: I hereby waive any confidentiality provision concerning the information provided in this application, pursuant to New York State Public Health Law section 2805-k.

1.	I agree to update this form while it is being processed, should there be any change in the information provided.	☐ TRUE ☐ FALSE
2.	I am not currently using any illegal drug, nor have I during the past two years.	☐ TRUE ☐ FALSE
3.	I authorize release of reference information by all past and present employers/educational institutions.	☐ TRUE ☐ FALSE
4.	I attest that the information provided is complete, true and accurate.	☐ TRUE ☐ FALSE
5.	I understand that any misrepresentation, misstatement or omission on this form could result in revocation of any privileges/employment granted and subject to reporting according to NYS regulations.	☐ TRUE ☐ FALSE

I acknowledge by my signature below that a drug test will be a condition of employment.

APPLICANT SIGNATURE _____ DATE: _____

APPLICANT PRINTED NAME _____

Please include your CV and Objectives for the Fellowship with this completed application and send to:

Jennie Gilardoni
Fellowship Coordinator
University of Rochester Medical Center
601 Elmwood Avenue, Box 777
Rochester, NY 14642
(585) 275-5798
Jennie_Gilardoni@urmc.rochester.edu