**Generic Graduate Medical Education Employment Application Form, see pages 2-6**

In addition to the generic application form, the program may also provide to/request from the applicant:

1) address to send application

2) request for a personal statement

3) request for CV

4) request availability about coming for a personal interview

5) other questions related to your discipline

6) etc.



**GRADUATE MEDICAL EDUCATION EMPLOYMENT APPLICATION FORM**

***Please Print/Type***

**Program Name Completing Application for:**

Photo

A recent photograph is not a requirement, but is very helpful

**Program Start Date:**

**Last Name:**

**Middle Name:**

**First Name:**

**Contact Address:**

**Permanent Address:**

|  |  |
| --- | --- |
| Home Phone Number: |  |
| Work Phone Number: |  |
| Cell Phone Number: |  |
| Fax Number: |  |
| Email: |  |
| National Provider Identifier Number: |  |
| Gender: |  |
| Ethnicity: |  |
| Race: |  |

|  |  |
| --- | --- |
| Birth Date: (mm/dd/yyyy) |  |
| Birth Place: |  |
| Citizenship Country: |  |
| Visa Type (if applicable): |  |

**Examinations**

|  |  |  |  |
| --- | --- | --- | --- |
| Examination | Status  (Passed/Failed) | 3- Digit Score | Date |
| USMLE Step 1 |  |  |  |
| USMLE Step 2 CK (clinical knowledge) |  |  |  |
| USMLE Step 2 (clinical skills) |  |  |  |
| USMLE Step 3 |  |  |  |

**Medical Licensure**

|  |  |
| --- | --- |
| Board Certification? (yes/no) |  |
| If yes, which Board: |  |
| Ever Named in a Malpractice Suit? (yes/no) |  |
| State Medical License? (yes/no) |  |
| If yes, which state, number, expiration date: |  |

**Educational Commission for Foreign Medical Graduates Certification**

|  |  |
| --- | --- |
| Are you certified by the ECFMG? (yes/no) |  |
| If yes, ECFMG Number: |  |

**Medical Education**

|  |  |  |  |
| --- | --- | --- | --- |
| Institution & Location | Dates Attended | Degree | Date of Degree  (mm/dd/yyyy) |
|  |  |  |  |
| Medical Education/Training Extended or  Interrupted? (yes/no) | |  | |
| If yes, the reason: | |  | |

**Medical Education Honors/Awards**

**Education (list all graduate and undergraduate schools)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Education (not medical) | Institution & Location | Dates  Attended | Degree | Degree Date  (mm/dd/yyyy) | Field of  Study |
| Graduate |  |  |  |  |  |
| Undergraduate |  |  |  |  |  |

**Current/Prior Medical Training**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Experience/Specialty | Institution & Location | Program  Director | Dates Attended  (mm/dd/yyyy) | Years of  Training |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Hospital and Clinical Work Experience**

|  |  |  |  |
| --- | --- | --- | --- |
| Position | Hospital/Practice  Name | City/State/Zip | Dates  From mm/dd/yyyy  To mm/dd/yyyy |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Publications**

**Language Fluency (other than English)**

**Hobbies & Interests**

**Other Awards/Accomplishments**

**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.**

1. Have you ever been reported to the National Practitioner Data Bank, Healthcare ................................  YES  NO

Integrity and/or Protection Data Bank?

2. Has your employment, medical staff appointment, panel participation, affiliation ...............................  YES  NO

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?

3. Has your license to practice your profession in any jurisdiction every been limited, ............................  YES  NO

restricted, suspended, revoked, denied or subject to probationary conditions?

4. Have you ever voluntarily or involuntarily relinquished your license to practice .................................  YES  NO

your profession in any state?

5. Have you ever been suspended, sanctioned or otherwise restricted from participating ..........................  YES  NO

in any private, federal or state health insurance program (including Medicare, Medicaid or a managed care organization)?

6. Has your narcotics registration certificate ever been voluntarily or involuntarily.................................  YES  NO

limited, restricted, denied renewal, suspended or revoked?

7. Have you ever been denied membership, membership renewal or been subject ..................................  YES  NO

to any professional review, censure or reprimand in any medical organization or professional society – local, state or national?

8. Have you ever been subject to disciplinary action by a state agency or .............................................  YES  NO

professional body (i.e., Medical Society, IPRO, OPMC)?

9. Has your specialty board certification or qualification ever been voluntarily or ..................................  YES  NO

involuntarily denied, revoked, relinquished, not renewed, suspended or reduced?

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, ..........  YES  NO

limitation, restriction, monitoring or probationary proceedings?

13. Have you ever been cited for violation of patient rights as set forth by the ......................................  YES  NO

Federal Law and/or NYS Department of Health or any other state department of health?

14. Has your professional liability insurance coverage ever been surcharged, suspended...............................  YES  NO

or terminated by action of any insurance company?

15. Has your professional liability insurance coverage ever been denied or not renewed ...............................  YES  NO

by action of any insurance company?

16. Has your present professional liability insurance carrier excluded any specific ........................................  YES  NO

procedures from your coverage? **If “Yes,” list the procedure(s), the date(s) the exclusion(s)**

**commenced in the space below.**

17. Have any professional liability suits been filed against you which are currently pending .........................  YES  NO

in this or any other state?

18. Have any professional liability judgments and/or settlements ever been made against ........................  YES  NO

you or on your behalf?

**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 attest that the information provided is complete, true and accurate. ................................................  TRUE  FALSE

2. I agree to update this form while it is being processed, should there be any .......................................  TRUE  FALSE

change in the information provided.

3. I understand that any misrepresentation, misstatement or omission on this form .................................  TRUE  FALSE

could result in revocation of any privileges/employment granted and subject to reporting according to NYS regulations.

4. I am not currently using any illegal drug, nor have I during the past two years. ..................................  TRUE  FALSE

5. I authorize release of reference information by all past and present employers/ ..................................  YES  NO

educational institutions.

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

DATE:

APPLICANT SIGNATURE

APPLICANT PRINTED NAME