EMPLOYMENT & FELLOWSHIP APPLICATION FORM
Headache Medicine Fellowship Program

Program Start Date: _____

Name: _____
(First) (Last)

Birth Date (mm/dd/yyyy): _____

Contact Address: _____ **Permanent Address**: _____

_____ _____
_____ _____
_____ _____

Home/Cell Phone Number: _____ **Work Phone Number**: _____

Email Address: _____

National Provider Identifier Number: _____

Birth Place: _____

Country of Citizenship: _____

VISA type (if applicable): _____

Language Fluency: _____

Education

	Institution & Location	Dates Attended	Major	Degree
Undergraduate				
Graduate				
Medical School				

Education Honors/Awards _____

_____

_____

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? _____

State Medical License? Yes No

If Yes, what state? _____

Number _____

Expiration Date: _____

Educational Commission for Foreign Medical Graduates Certification

Are you certified by the ECFMG? Yes No

If Yes, ECFMG Number: _____

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

Publications

Other Awards/Accomplishments

Hobbies & Interests

Special Considerations

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) Has your medical education/training ever been extended or interrupted? Yes No

2) Have you ever been named in a malpractice suit? Yes No

3) Have you ever been reported to the National Practitioner Data Bank, Healthcare Integrity and/or Protection Data Bank? Yes No

4) 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

5) Has your license to practice your profession in any jurisdiction ever been limited, restricted, suspended, revoked, denied or subject to probationary conditions? Yes No

6) Have you ever voluntarily or involuntarily relinquished your license to practice your profession in any state? Yes No

7) 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

8) Has your narcotics registration certificate ever been voluntarily or involuntarily limited, restricted, denied renewal, suspended or revoked? Yes No

9) 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

10) Have you ever been subject to disciplinary action by a state agency or professional body (i.e., Medical Society, IPRO, OPMC)? Yes No

11) Has your specialty board certification or qualification ever been voluntarily or involuntarily denied, revoked, relinquished, not renewed, suspended or reduced? Yes No

12) Do you have any pending misconduct charges against you in this state or any other state? Yes No

13) Have you ever been convicted of a misdemeanor or felony in any jurisdiction? Yes No

14) Are you presently or have you ever been subject to any suspension, revocation, discontinuance, limitation, restriction, monitoring or probationary proceedings? Yes No

15) 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

16) Has your professional liability insurance coverage ever been surcharged, suspended or terminated by action of any insurance company? Yes No

17) Has your professional liability insurance coverage ever been denied or not renewed by action of any insurance company? Yes No

18) Has your present professional liability insurance carrier excluded any specific procedures from your coverage? Yes No

19) Have any professional liability suits been filed against you which are currently pending in this or any other state? Yes No

20) Have any professional liability judgments and/or settlements ever been made against you or on your behalf? Yes No

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

_____
_____
_____
_____
_____
_____
_____
_____

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.

I attest that the information provided is complete, true and accurate.

I agree to update this form while it is being processed should there be any change in the information provided.

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.

I am not currently using any illegal drug, nor have I in the past two years.

I authorize release of reference information by all past and present employers/educational institutions.

Applicant Signature: _____

Applicant Printed Name: _____

Date: _____