GRADUATE MEDICAL EDUCATION EMPLOYMENT APPLICATION

Please Print or Type

Program Applying To:

Please select program

Desired Start Date: (MM/YYYY)

Photo

(optional)

Please complete the following information and submit with at least three (3) references, CV, personal statement, USMLE / COMLEX score report (as appropriate), and ECFMG certificate (if applicable). Additional documentation may be requested prior to extending an offer.

Last Name:

First Name:

Middle Name:

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:				
Gender:	☐ MALE ☐ FEMALE			
Date of Birth (MM/DD/YYYY):				
Place of Birth:				
Country of Citizenship:				
For Foreign Nationals:	Current Visa Type:	Choose	Requested Visa Type:	Choose

Optional:
Ethnicity:
Race:

Examinations: Please indicate ☐ **USMLE** ☐ **COMLEX**

Examination	Status:	Numeric Score	Date (MM/YYYY)
USMLE Step 1 / COMLEX-USA Level 1	☐ PASS ☐ FAIL		
USMLE Step 2 Clinical Knowledge / COMLEX-USA Level 2 Cognitive Evaluation	☐ PASS ☐ FAIL		
USMLE Step 2 Clinical Skills / COMLEX-USA Level 2 Performance Evaluation	☐ PASS ☐ FAIL	*Not Applicable*	
USMLE Step 3 / COMLEX-USA Level 3	☐ PASS ☐ FAIL		

Medical Licensure

Board Certified?	☐ YES ☐ NO
If yes, which Board:	
Ever Named in a Malpractice Suit?	☐ YES ☐ NO
State Medical License?	☐ YES ☐ NO
If yes, specify state, number, expiration date:	

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.

Medical Education

Institution & Location	Dates Attended (MM/YYYY – MM/YYYY)	Degree	Degree Date (MM/YYYY)
Medical Education/Training Extended or Interrupted? ☐ YES ☐ NO			
If yes, the reason:			

Medical Education Honors/Awards

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					

Current / Prior Medical Training

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

Hospital and Clinical Work Experience

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

Research Experience & Area(s) of Interest

Publications

Other Awards & Accomplishments

Language Fluency (other than English)

Hobbies & Interests

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 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 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 change in the information provided.	☐ TRUE	☐ FALSE
3.	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
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/educational institutions.	☐ TRUE	☐ FALSE

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

APPLICANT SIGNATURE _____ DATE: _____

APPLICANT PRINTED NAME _____