UNIVERSITY of ROCHESTER MEDICAL CENTER

GRADUATE MEDICAL EDUCATION EMPLOYMENT APPLICATION FORM

Please Print/Type

Photo

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

Program Name Completing Application for:

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:	
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 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 every 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

3. I authorize release of reference information by all past and present employers/ educational institutions. ..... ☐ YES ☐ NO

DATE: _____ APPLICANT SIGNATURE_____

APPLICANT PRINTED NAME_____