

GENERAL PERSONAL INFORMATION

Last Name	First Name	Middle Name	Degree(s) (please circle) MD DO MPH MPA MBBS Other _____	Social Security No.
I Am Entering The Following Graduate Program:				Date(s) previously rotated at BIMC:
Appointment Start Date:	NRMP Participant <input type="checkbox"/> Yes <input type="checkbox"/> No	Citizenship: <input type="checkbox"/> U.S. <input type="checkbox"/> Other _____		
POSITION: <input type="checkbox"/> Internship <input type="checkbox"/> Resident <input type="checkbox"/> Fellow in an Accredited Program <input type="checkbox"/> Fellow in a Non-Accredited Program <input type="checkbox"/> Rotator Have you ever worked for a Division of CHP, Inc.? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Department: _____ Site: _____ From: _____ To: _____ Do you have relative(s) working for a Division of CHP? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Department: _____ Site: _____ From: _____ To: _____				
Visa Status (If Not a US Citizen) PLEASE ATTACH COPY OF PROOF OF VISA STATUS				
<input type="checkbox"/> J-1 <input type="checkbox"/> J-2 <input type="checkbox"/> H-1B <input type="checkbox"/> Other _____ <input type="checkbox"/> Permanent Alien Registration # _____ Issue Date: _____ Expiration of Status: (Date): _____				
ECFMG # (or <input type="checkbox"/> Fifth Pathway) _____			ECFMG Certificate Valid Indefinitely: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Issue Date: _____			If "No", Expiration Date: _____	
Other/Former/Maiden Name (If Applicable)	Date Of Birth / /	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Country Of Birth	Ethnicity
Home Address / Street	Apt. #	City	State	Zip Code
Home Phone:				
Preferred Mailing Address / Street	Apt. #	City	State	Zip Code
Preferred Phone:				
E-Mail Address:	Beeper:	Fax Number:		
1st In Case Of Emergency Contact Name:	Relationship:	(Area Code) Phone Number (H) () (W) () (C) ()		
Address: Street Address, City, State, Zip Code, Country			Languages Spoken	
2nd In Case Of Emergency Contact Name:	Relationship:	(Area Code) Phone Number (H) () (W) () (C) ()		
Address: Street Address, City, State, Zip Code, Country			Languages Spoken	
3rd In Case Of Emergency Contact Name:	Relationship:	(Area Code) Phone Number (H) () (W) () (C) ()		
Address: Street Address, City, State, Zip Code, Country			Languages Spoken	

EDUCATION

Graduate Education

Institution Name			
Street	City	State/Country	Zip Code
Dates Attended (MM/DD/YYYY)	From	To	
Program			
Did You Successfully Complete This Program?		Degree Conferred (MM/DD/YYYY):	
<input type="checkbox"/> Yes <input type="checkbox"/> No			

Undergraduate Education

Institution Name			
Street	City	State/Country	Zip/Country Code
Degree (state degree & bring in proof for it to appear on the graduating diploma)	Graduation Date (Date Degree was Conferred) (MM/DD/YYYY)	Dates Attended From (MM/DD/YYYY)	To: (MM/DD/YYYY)



Processing Form for
RESIDENT/FELLOW/ROTATOR
 Academic Year 2008 - 2009

BIMC
 LICH
 SLRHC
 ("HOSPITAL")

Medical School

Institution Name			
Street	City	State/Country	Zip/Country Code
Degree (state degree & bring in proof for it to appear on the graduating diploma)		Graduation Date (EXACT Date Degree was Conferred) (MM/DD/YYYY)	Dates Attended From (MM/DD/YYYY) To: (MM/DD/YYYY)

TRAINING (U.S. Only)

Internship

Institution Name			
Street	City	State/Country	Zip Code
Program Name/Specialty		Dates Attended From (MM/DD/YYYY) To: (MM/DD/YYYY)	
Did You Successfully Complete This Program? <input type="checkbox"/> Yes <input type="checkbox"/> No		ACGME / ADA Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	

First Residency Training

Institution Name			
Street	City	State/Country	Zip Code
Program Name/Specialty		Dates Attended From (MM/DD/YYYY) To: (MM/DD/YYYY)	
Did You Successfully Complete This Program? <input type="checkbox"/> Yes <input type="checkbox"/> No		ACGME / ADA Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	

Second Residency (If Additional Residencies, Please Attach a Separate Sheet)

Institution Name			
Street	City	State/Country	Zip Code
Program Name/Specialty		Dates Attended From (MM/DD/YYYY) To: (MM/DD/YYYY)	
Did You Successfully Complete This Program? <input type="checkbox"/> Yes <input type="checkbox"/> No		ACGME / ADA Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	

Fellowship/Training

Institution Name			
Street	City	State/Country	Zip Code
Fellowship Program Name/Sub-Specialty		Dates Attended From (MM/DD/YYYY) To: (MM/DD/YYYY)	
Did You Successfully Complete This Program? <input type="checkbox"/> Yes <input type="checkbox"/> No		ACGME / ADA Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	

Second Fellowship (If Additional Fellowships, Please Attach a Separate Sheet)

Institution Name			
Street	City	State/Country	Zip Code
Fellowship Program Name/Sub-Specialty		Dates Attended From (MM/DD/YYYY) To: (MM/DD/YYYY)	
Did You Successfully Complete This Program? <input type="checkbox"/> Yes <input type="checkbox"/> No		ACGME / ADA Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	

EXAMINATIONS/LICENSURE

(if you're in an accredited or non-accredited program, license information is MANDATORY if you possess one)

ALREADY PASSED:

USMLE Step II Clinical Skills (C.S.): Issue Date _____ Clinical Knowledge (C.K.): Issue Date _____

Number of years between C.S. & C.K. _____

USMLE Step III Issue Date _____ Expiration Date _____ Number of years between Step 2 & Step 3 _____

BCLS Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No	Issue Date _____ Expiration Date _____	PALS Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No	Issue Date _____ Expiration Date _____
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ACLS Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No	Issue Date _____ Expiration Date _____	NALS Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No	Issue Date _____ Expiration Date _____
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License: New York State? <input type="checkbox"/> Yes <input type="checkbox"/> No	License Number _____	Issue Date _____	Expiration Date _____	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Limited <input type="checkbox"/> Other
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Do You Have A License In **Any** Other State or Country? Yes No STATE: _____ COUNTRY: _____

License Number :	Issue Date _____	Expiration Date _____	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Limited <input type="checkbox"/> Other
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NPI (National Provider Index), if applicable _____

Federal DEA Number	Issue Date _____	Expiration Date _____
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State DEA/CDS (If Applicable)	Issue Date _____	Expiration Date _____
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EMPLOYMENT HISTORY/WORK EXPERIENCE

(Start with most recent Employer) - (Employment information will be Verified)

May We Contact Your Present Employee: Yes No

CURRENT/ MOST RECENT	Organization:	Your Supervisor:	Telephone No.:	
DATE	Your Department:	Your Title:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Perm Diem <input type="checkbox"/> Temporary	
FROM TO	Street Address	City	State	Zip Code Final Salary

Describe Duties:

Reason for Leaving:

May We Contact Your Present Employee: Yes No

PREVIOUS	Organization:	Your Supervisor:	Telephone No.:	
DATE	Your Department:	Your Title:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Perm Diem <input type="checkbox"/> Temporary	
FROM TO	Street Address	City	State	Zip Code Final Salary

Describe Duties:

Reason for Leaving:

May We Contact Your Present Employee: Yes No

NEXT PREVIOUS	Organization:	Your Supervisor:	Telephone No.:	
DATE	Your Department:	Your Title:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Perm Diem <input type="checkbox"/> Temporary	
FROM TO	Street Address	City	State	Zip Code Final Salary

Describe Duties:

Reason for Leaving:

May We Contact Your Present Employee: Yes No

NEXT PREVIOUS	Organization:	Your Supervisor:	Telephone No.:	
DATE	Your Department:	Your Title:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Perm Diem <input type="checkbox"/> Temporary	
FROM TO	Street Address	City	State	Zip Code Final Salary

Describe Duties:

Reason for Leaving:



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___ BIMC
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___ SLRHC
("HOSPITAL")

PROFESSIONAL REFERENCES
(Not required for rotators to/from BIMC & SLRHC)

Please List (at least) 3 Professional References 1- Dean's Letter from Degree Granting Institution and 2 from the Physicians who most recently supervised your clinical work.

1. Name		Telephone	
Street Address			
City		State	Zip Code
2. Name		Telephone	
Street Address			
City		State	Zip Code
3. Name		Telephone	
Street Address			
City		State	Zip Code

SERVICE OBLIGATIONS
(National Health Service Corps, Armed Forces Scholarship, State Programs, etc.)

I Am Not Required To Fulfill Any Service Obligations

I Am Committed To Fulfill A Service Obligation Beginning

U.S Military Branch: _____ Duties: _____ From: _____ To: _____

TRAINING and EMPLOYMENT INTERRUPTIONS
(including resignations and terminations)

Have there been any interruptions in your training? Yes No If yes, a written and signed explanation with date is necessary as well as proof from any institution/organization that you have worked for during those period (attach separate sheet)

Have you ever resigned (or been forced to resign), or been terminated from a training program? Yes No If yes, please explain, sign and date (attach separate sheet)

Have you ever resigned (or been forced to resign), or been terminated from any employment? Yes No If yes, please explain, sign and date (attach separate sheet)

CRIMINAL HISTORY

HAVE YOU EVER BEEN CONVICTED OF A CRIME? Yes No **NOTE:** A plea of guilty is considered a conviction and both misdemeanors and felonies are considered crimes. (Responding "YES" will not necessarily nullify your appointment. The nature of the offense will be considered.)

If "YES", WHAT AND WHEN: _____

MISCELLANEOUS

Have you ever been excluded, debarred or otherwise ineligible to participate in the Medicare, Medicaid or any other federal health care program or in any federal procurement or non-procurement program? Yes No

Have your medical/dental staff appointment/employment status or clinical privileges in any hospital or health care facility ever been denied, revoked, suspended, restricted, reduced, limited, placed in probation, not renewed, voluntarily relinquished, discontinued or otherwise changed, including any leaves of absence? Yes No

Has your license/registration even been suspended/revoked? Yes No

Are there currently any pending investigations into, or have you ever voluntarily relinquished, your DEA registration? Yes No

Is your license/registration under review or suspension? Yes No

If you answered "Yes" to any of the above please give date(s) and explain (**attach an additional sheet, if necessary**)

CONSENT and RELEASE signed and attached (last page) Yes
(This form will not be processed without a signed consent and release form.)

Are any required additional pages (explanations, etc.) included? Yes
(This form will not be processed unless fully complete, including all attachments.)

Hospital does not discriminate on the basis of actual or perceived age, race, creed, color, ethnicity, gender, disability, marital status, sexual orientation, national origin or citizen status/veterans status or on the basis of any other characteristic protected by law.

I affirm under the penalty of perjury, that all information submitted by me in this processing form is true, complete and accurate. I understand that any significant misstatements and/or omissions from the processing form may be cause for dismissal of appointment.

Signature and Academic Degree

Date

Name (please print)

OPTIONAL INFORMATION: *(For Statistical Reporting as Requested by State and Federal Government Agencies.)*

Marital Status: Single Married Separated Divorced Legally Separated Other _____

Military Reporting Status: Vietnam Veteran Vietnam Veteran with Disability Non Vietnam Veteran Other

U.S. Military Branch: Duties: _____ From: _____ To: _____

Languages Spoken: _____
 Fluent Good Fair Fluent Good Fair Fluent Good Fair Fluent Good Fair

I Understand Sign Language: Yes No



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CONSENT AND RELEASE AUTHORIZATION FORM

By submitting this processing form to become a member of the Continuum Health Partners, Inc. House Staff (either as a full time trainee or rotator), I hereby:

- ❖ Authorize representatives of the institutions under the Hospital checked above to consult with representatives of other health care related facilities with which I have been associated and with others who may have information bearing on my competence, character, health status, ethics and other qualifications for staff membership and privileges;
- ❖ Authorize representatives of Hospital to query health care related facilities and/or professional persons with which/whom I will become associated after graduation, for information bearing on my competence, ethics and professional performance post-graduation to help evaluate the residency training program (all such information will be kept strictly confidential);
- ❖ Consent to the inspection by representatives of Hospital of all records and documents that may be material to an evaluation of my competence, character, health status, ethics and other professional qualifications for staff membership and privileges;
- ❖ Release from any liability all representatives of Hospital including their medical staff(s) and allied health professional staff(s) for their acts performed and statements made in good faith and without malice in connection with evaluating my processing form, credentials and qualifications for staff membership and privileges, including privileged or otherwise confidential information;
- ❖ Release from any liability all individuals and organizations who provide information to representatives of Hospital and their medical staff(s) and allied health professional staff(s) in good faith and without malice concerning my competence, character, health status, ethics and other qualifications for staff membership and privileges, including privileged or otherwise confidential information;
- ❖ Authorize representatives of Hospital including their medical staff(s) and allied health professional staff(s) to provide to health care facilities, medical associations, licensing boards and other health care related entities any information relevant to me, including otherwise privileged or confidential information, and release from any liability all representatives of Hospital.
- ❖ Affirm that all information submitted by me in this processing form is true to the best of my knowledge and belief, and I understand that any significant misstatements and/or omissions from the processing form may be the cause for dismissal or denial of appointment.
- ❖ I acknowledge that I may perform clinical rotations at other hospitals, including hospitals that are part of the Continuum Health Partners, Inc. system, Beth Israel Medical Center (BIMC), St. Luke's Roosevelt Hospital Center (SLRHC) and Long Island College Hospital (LICH). I agree that if I rotate to another Continuum Health Partners, Inc. hospital this processing form, and my credentialing documents and information, may be copied and shared with such hospital(s).

THIS FORM WILL NOT BE PROCESSED UNLESS ALL REQUESTED INFORMATION HAS BEEN SUPPLIED.

Signature

Date

Name (please print)