



Processing Form for  
RESIDENT/FELLOW/ROTATOR  
Academic Year 2011 - 2012

BIMC  
 LICH  
 SLRHC

**GENERAL PERSONAL INFORMATION**

Last Name	First Name	Middle Name	Degree(s) (please circle) MD DO MPH MBBS Other _____	Social Security No.
I Am Entering The Following Graduate Program:				
Appointment Start Date:	NRMP Participant <input type="checkbox"/> Yes <input type="checkbox"/> No	Citizenship: <input type="checkbox"/> U.S. <input type="checkbox"/> Other _____		
Applying As: <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: _____				
<b>Visa Status (If Not a US Citizen) PLEASE ATTACH COPY OF PROOF OF VISA STATUS</b>				
<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:	
<b>1<sup>st</sup></b> In Case Of Emergency Contact Name:	Relationship:	Phone Number (Area Code) (H) ( ) ( ) (W) ( ) ( ) (C) ( ) ( )		
Address: Street Address, City, State, Zip Code, Country			Languages Spoken	
<b>2<sup>nd</sup></b> In Case Of Emergency Contact Name:	Relationship:	Phone Number (Area Code) (H) ( ) ( ) (W) ( ) ( ) (C) ( ) ( )		
Address: Street Address, City, State, Zip Code, Country			Languages Spoken	
<b>3<sup>rd</sup></b> In Case Of Emergency Contact Name:	Relationship:	Phone Number (Area Code) (H) ( ) ( ) (W) ( ) ( ) (C) ( ) ( )		
Address: Street Address, City, State, Zip Code, Country			Languages Spoken	

**EDUCATION \*(ERAS Application Acceptable- Please attach to this form)**

**Graduate Education**

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

**Undergraduate Education**

Institution Name			
Street	City	State/Country	Zip/Country Code
Degree	Graduation Date (Date Degree was Conferred) (MM/DD/YYYY)	Dates Attended From (MM/DD/YYYY)	To: (MM/DD/YYYY)

<b>Medical School</b>			
Institution Name			
Street	City	State/Country	Zip/Country Code
Degree	Graduation Date (EXACT Date Degree was Conferred) (MM/DD/YYYY)	Dates Attended From (MM/DD/YYYY)	To: (MM/DD/YYYY)
<b>TRAINING (U.S. Only) *(ERAS Application Acceptable- Please attach to this form)</b>			
<b>Internship</b>			
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		
<b>First Residency Training</b>			
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		
<b>Second Residency (If Additional Residencies, Please Attach a Separate Sheet)</b>			
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		
<b>Fellowship/Training</b>			
Institution Name			
Street	City	State/Country	Zip Code
Fellowship Program Name/SubSpecialty	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		
<b>Second Fellowship (If Additional Fellowships, Please Attach a Separate Sheet)</b>			
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		



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**EXAMINATIONS/LICENSURE**

**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:  Yes  No Issue Date \_\_\_\_\_ PALS Certified:  Yes  No Issue Date \_\_\_\_\_  
Expiration Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

ACLS Certified:  Yes  No Issue Date \_\_\_\_\_ NALS Certified:  Yes  No Issue Date \_\_\_\_\_  
Expiration Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

License: New York State?  Yes  No License Number \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_  Permanent  Temporary  
 Limited  Other

Do You Have A License In Any Other State or Country?  Yes  No STATE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_

License Number : \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_  Permanent  Temporary  
 Limited  Other

NPI (National Provider Index), if applicable \_\_\_\_\_

Federal DEA Number \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

State DEA/CDS (If Applicable) \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

**EMPLOYMENT HISTORY/WORK EXPERIENCE**

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

May We Contact Your Present Employer:  Yes  No

**CURRENT/ MOST RECENT** Organization: \_\_\_\_\_ Your Supervisor: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

**DATE** Your Department: \_\_\_\_\_ Your Title: \_\_\_\_\_  Full Time  Part Time  
 Perm Diem  Temporary

**FROM TO** Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Final Salary \_\_\_\_\_

Describe Duties \_\_\_\_\_

Reason for Leaving \_\_\_\_\_

May We Contact Your Present Employer:  Yes  No

**PREVIOUS** Organization: \_\_\_\_\_ Your Supervisor: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

**DATE** Your Department: \_\_\_\_\_ Your Title: \_\_\_\_\_  Full Time  Part Time  
 Perm Diem  Temporary

**FROM TO** Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Final Salary \_\_\_\_\_

Describe Duties \_\_\_\_\_

Reason for Leaving \_\_\_\_\_

May We Contact Your Present Employer:  Yes  No

**NEXT PREVIOUS** Organization: \_\_\_\_\_ Your Supervisor: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

**DATE** Your Department: \_\_\_\_\_ Your Title: \_\_\_\_\_  Full Time  Part Time  
 Perm Diem  Temporary

**FROM TO** Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Final Salary \_\_\_\_\_

Describe Duties \_\_\_\_\_

Reason for Leaving \_\_\_\_\_

May We Contact Your Present Employer:  Yes  No

**NEXT PREVIOUS** Organization: \_\_\_\_\_ Your Supervisor: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

**DATE** Your Department: \_\_\_\_\_ Your Title: \_\_\_\_\_  Full Time  Part Time  
 Perm Diem  Temporary

**FROM TO** Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Final Salary \_\_\_\_\_

Describe Duties \_\_\_\_\_

Reason for Leaving \_\_\_\_\_

**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 eliminate you from consideration. The nature of the offense will be considered in relation to the position for which you are being considered.)

If "YES", WHAT AND WHEN: \_\_\_\_\_



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**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.)

Continuum Health Partners, Inc. 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 application processing form may be cause for dismissal or denial 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



## 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 Continuum Health Partners, Inc. (CHP) 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 Continuum Health Partners, Inc. 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 Continuum Health Partners, Inc. 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 Continuum Health Partners, Inc. 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 Continuum Health Partners, Inc. 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 Continuum Health Partners, Inc. 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 Continuum Health Partners, Inc.
- ❖ 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 not part of the Continuum Health Partners, Inc. system, BIMC, SLRHC and LICH. I agree that if I rotate to another Continuum Health Partners, Inc. hospital this application, 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)**