



Processing Form for
RESIDENT/FELLOW/ROTATOR
Academic Year 2010 - 2011

___ 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: Internship Resident Fellow in an Accredited Program Fellow in a Non-Accredited Program Rotator
 Have you ever worked for a Division of CHP, Inc.? Yes No If yes, Department: _____ Site: _____ From: _____ To: _____
 Do you have relative(s) working for a Division of CHP? Yes No If yes, Department: _____ Site: _____ From: _____ To: _____

Visa Status (If Not a US Citizen) PLEASE ATTACH COPY OF PROOF OF VISA STATUS
 J-1 J-2 H-1B Other _____ Permanent Alien Registration # _____
 Issue Date: _____ Expiration of Status: (Date): _____

| | |
|--|---|
| ECFMG # (or <input type="checkbox"/> Fifth Pathway) _____ Issue Date: _____ | ECFMG Certificate Valid Indefinitely: <input type="checkbox"/> Yes <input type="checkbox"/> No 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: | Phone Number (Area Code) (H) () (W) () (C) () |
|--|---------------|---|

| | |
|---|------------------|
| Address: Street Address, City, State, Zip Code, Country | Languages Spoken |
|---|------------------|

| | | |
|--|---------------|---|
| 2nd In Case Of Emergency Contact Name: | Relationship: | Phone Number (Area Code) (H) () (W) () (C) () |
|--|---------------|---|

| | |
|---|------------------|
| Address: Street Address, City, State, Zip Code, Country | Languages Spoken |
|---|------------------|

| | | |
|--|---------------|---|
| 3rd 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) |
|--------|--|--|

Medical School

| | | | |
|------------------|--|----------------------------------|------------------|
| 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) |

TRAINING (U.S. Only) *(ERAS Application Acceptable- Please attach to this form)

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/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 | | |

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 | | |



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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 _____ Expiration Date _____

PALS Certified: Yes No Issue Date _____ Expiration Date _____

ACLS Certified: Yes No Issue Date _____ Expiration Date _____

NALS Certified: Yes No Issue 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



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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)