Tufts New England Medical Center

INITIAL APPLICATION FOR APPOINTMENT TO THE HOUSE STAFF

Check whichever is applicable:

- ☐ **Residency Program in :**_____**(Please fill in the blank)**
- ☐ **Fellowship Program in:**_____**(Please fill in the blank)**

BACKGROUND INFORMATION (*PRINT LEGIBLY OR TYPE ALL RESPONSES*)

NAME_____
Last First MI

_____ Home Phone: (_____)_____
RESIDENCE ADDRESS

_____ Birth Date: _____/ _____/ _____
City State Zip

Social Security Number: __ __ __-__ __-__ __ __ Citizenship:_____
Attach copy of Visa if not a U.S. Citizen

Personal Email Address: _____

If applicable:

_____ Phone No.(_____)_____
BUSINESS ADDRESS (INCLUDE PRACTICE NAME)

_____ Fax No (_____) _____

_____ E-Mail_____
CITY STATE ZIP

EMERGENCY CONTACT:_____
NAME_____
Last First MI

_____ Home Phone: (_____)_____
ADDRESS

_____ Relationship: _____
City State Zip

EDUCATION

Undergraduate

Institution_____ Attendance: From__/___/___ To__/___/___
_____ Degree(s)_____
Address

_____
City State Zip

Medical/Podiatric/Osteopathic School

School_____ Attendance: From___/___/___ To___/___/___
Degree(s)_____

Address_____ _____
City State Zip

Graduate School

School_____ Attendance: From___/___/___ To__/___/__
Degree(s)_____

Address_____ _____
City State Zip

Other Postgraduate Training

School_____ Attendance: From__/___/__ To__/___/___
Degree(s)_____

Address_____ _____
City State Zip

TRAINING List Internships, Residencies, Fellowships **(*please provide explanation on separate sheet of paper for any absence from training and/or gaps in career progression*)**

1. **Name of Hospital** _____ Program Director_____

   Type of Program _____ From___/___/___ To___/___/___

2. **Name of Hospital** _____ Program Director_____

   Type of Program _____ From___/___/___ To___/___/___

3. **Name of Hospital** _____ Program Director_____

   Type of Program _____ From___/___/___ To___/___/___

CERTIFICATION *Attach certificates as applicable*_____

Specialty Board Certified? Yes_____ No:_____ or Eligible? Yes_____ No_____

Certified by: American_____ Date:_____ Recertified:_____

Subspecialty Board Certified? Yes_____ No:_____or Eligible? Yes_____ No_____

Certified in Subspecialty of:_____ Date:_____ Recertified:_____

National Board of Medical Examiners (check one) _____ Yes _____No

USMLE Step 1 Pass Date _____ Step 2 Pass Date _____ Step 3 Pass Date_____

ECFMG#_____ ***Attach copy of your valid ECFMG certificate***.

Issue Date _____ Valid Indefinitely? _____ Expiration Date_____

FLEX Cert.#_____ Issue Date_____

LICENSURE
If applicable, attach copy of current license. If M.D. ,submit copy of most recent application to practice medicine in Massachusetts

MA Medical/Dental/Podiatric/Psychology/Other License #_____ Exp. Date:_____

Other States: State:_____ License #_____ Exp. Date:_____

State:_____ License #_____ Exp. Date:_____

Federal DEA #_____ Issue Date:_____ Exp. Date:_____

Massachusetts DEA (MA) #_____ Issue Date:_____

EMPLOYMENT OR ASSOCIATION WITH OTHER HOSPITAL STAFFS (PAST AND PRESENT) ***Please provide explanation for any gaps in career progression***

Institution:_____ Staff Category:_____

Department_____ Dates of Affiliation_____

Address:_____

Reason for Discontinuation:_____

Institution _____ Staff Category:_____

Department:_____ Dates of Affiliation:_____

Address:_____

Reason for Discontinuation:_____

Institution: _____ Staff Category:_____

Department:_____ Dates of Affiliation:_____

Address:_____

Reason for Discontinuation:_____

PROFESSIONAL LIABILITY INSURANCE: Please attach a copy/or copies of your current Certificate of Insurance. Please list Professional Liability Insurance Carriers in effect for the PAST 10 YEARS.

Current Insurance Carrier:_____

Address:_____

Policy Number:_____ Dates of Coverage:_____

2) Insurance Carrier:_____

Address:_____

Policy Number:_____ Dates of Coverage:_____

Amounts of Coverage:_____

MEMBERSHIPS
List Memberships in Medical, Dental or other Professional Societies

_____ Date:___/___/___
NAME To: ___/___/___

_____
REASON FOR DISCONTINUATION

_____ Date:___/___/___
NAME To: ___/___/___

_____
REASON FOR DISCONTINUATION

PROFESSIONAL REFERENCES:

Name:_____ Telephone: (__)_____

Title: _____ Department:_____

Address:_____ _____
City State Zip

Name:_____ Telephone:(___)_____

Title:_____ Department:_____

Address:_____ _____
City State Zip

CONFIDENTIAL PEER REVIEW INFORMATION

CLAIMS EXPIRIENCE FOR THE PAST TEN YEARS ONLY (*PLEASE USE ONE SHEET FOR EACH PAST/PRESENT, CLAIM/SUIT) IF ADDITIONAL SHEETS ARE NESCESSARY, PLEASE XEROX*.

DO YOU HAVE ANY PENDING OR CLOSED MALPRACTICE CLAIMS, SUITS OR SETTLEMENTS AGAINST YOU?
_____YES _____ NO

IF YOU ANSWERED YES TO THE ABOVE, PLEASE GIVE FULL DETAILS:

1) NAME OF CLAIMANT-PLAINTIFF:_____

2) AGE OF CLAIMAN-PLAINTIFF:_____

3) NATURE AND SUBSTANCE OF CLAIM:_____

4) DATE AND PLACE AT WHICH CLAIM AROSE:_____

5) STATUS:_____

6) DATE OF FINAL DISPOSTION:_____

7) REASON FOR FINAL DISPOSTION:_____

8) AMOUNTS PAID (IF ANY):_____

CONFIDENTIAL PEER REVIEW INFORMATION SANCTIONS/DISCIPLINARY ACTIONS

Have any of the following ever been, or are any in the process of being involuntarily or voluntarily or voluntarily limited, denied, revoked, suspended, reduced or not renewed:

	PLEASE CIRCLE ONE	
Licensure to practice your profession in any jurisdiction	YES	NO
Specialty Board Certification/eligibility	YES	NO
Participation in Medicare, Medicaid Programs; Drug Enforcement Agency Registration; State Controlled Substance Registration	YES	NO

Have any of the following ever been involuntarily or voluntarily or voluntarily limited, denied, revoked, suspended, reduced, relinquished; or voluntarily, as a result of or during the course of an investigation, limited, reduced, relinquished or withdrawn; or is such an investigation now in progress:

Staff membership or status of privileges at any other hospital, health care institution or professional organization?	YES	NO
Membership/fellowship in any healthcare organization or Professional society, local, state or national?	YES	NO
Educational programs or degrees; academic appointments; research Under any Federal or private Grants?	YES	NO
Have you ever been convicted of a criminal offense?	YES	NO
Do you have any impairments, physical or mental, which would interfere with your ability to perform the functions of the staff privileges for which you are currently applying?	YES	NO
)Have you participated voluntarily or involuntarily in a course of counseling, treatment, or testing for drug or alcohol abuse?	YES	NO
Have there ever been any pending, threatened, or final disciplinary or other adverse action (whether voluntary or involuntary) taken by any healthcare facility, professional organization or licensing or regulatory agency?	YES	NO
Have you been denied professional liability insurance or has your coverage been cancelled within the last 5 years	YES	NO

If the answer to any of the above questions is "yes", please provide full details below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

HEALTH STATUS

1. Are you able to perform the procedures and the essential functions of the position for which you have applied or requested privileges, accommodation, according to accepted standards of professional performance and without posing a direct threat to patients? _____ YES _____ NO

2. Are you currently engaged in illegal use of drugs? _____ YES _____ NO

3. Have you used illegal drugs within the last 2 years? _____ YES _____ NO

ADDITIONAL INFORMATION

1. Languages, other than English, in which you are fluent:

_____

2. UPIN Number (if applicable):_____

PHYSICIAN'S STATEMENT

I am applying for a position in a training program at Tufts -New England Medical Center in :_____

If my application is approved, I agree to acknowledge my obligation to observe the clinical practices of my program, and to adhere to the ethical standards of my profession. I understand that my performance will be periodically evaluated by my Program Director and other faculty as may be designated by him/her.

I agree to abide by all applicable policies, procedures, rules and regulations of either Tufts-New England Center itself, or my program specifically during the term of my training program. I agree to limit my practice to the scope stated in my program materials.

If I am training at Tufts-New England Medical Center on a visa sponsored by ECFMG I will promptly notify the Tufts-New England Medical Center's Department of Education of my address change, travel outside the United States, birth of children, or other data that may be required by U.S. law.

All information submitted by me in this application is true to the best of my knowledge and belief.

_____ _____

SIGNATURE DATE

_____

PRINT NAME

AUTHORIZATION FORM

Authorization – Pursuant to regulations of the Massachusetts Board of Registration in Medicine (243 CMR 3.05):

1. I authorize Tufts-New England Medical Center Hospital to contact any individuals or institution that may be able to provide information relevant to the consideration of this application including any voluntary or involuntary course of counseling, treatment or testing for drug or alcohol abuse.

2. I also authorize Tufts-New England Medical Center Hospital to request from all professional liability insurance carriers of which I have been or am insured. a listing of my malpractice claim history.

3. I also agree to undergo a mental or physical examination at any time if requested by Tufts-New England Medical Center Hospital, and if there is a known mental or physical impairment, to provide evidence that the impairment does not interfere with my competence to practice medicine. In addition, I agree to appear for an interview fi requested.

4. I authorize Tufts-New England Medical Center Hospital to query the National Practitioner Data Bank and other external agencies as may be deemed necessary in connection with my application for appointment.

5. I authorize Tufts-New England Medical Center Hospital to exchange information regarding my appointments status with other health is entities to include but not necessarily be limited to hospitals, HMOs and other third parties.

I hereby release from liability any and all representatives of Tufts-New England Medical Center Hospital and its medical staff for their acts performed in good fait and without malice in connection with evaluating my application, credentials and qualifications, and hereby release from liability any and all individuals and organizations who, in good faith without malice, provide information to Tufts-New England Medical Center Hospital or to its authorized medical staff representatives, concerning my professional competence, ethics, charter, and other qualifications for staff appointment and clinical privileges and I hereby consent to the release of such information to Tufts-New England Medical Center Hospital.

_____ _____

SIGNATURE DATE

_____

PRINT NAME

ATTACHMENTS

I have attached the following documents to this application:

___ECFMG Certificate ___Visa ___Certificate(s) of Insurance

___Confidential Peer Review Information ___Other _____