

B. Education & Certification

1. Physician Assistant Program

Name of Program and/or School

City State From _____
Month/Year

Credentials/Degrees Awarded To _____
Month/Year

2. NCCPA*Certification

Number Year

3. List all Undergraduate and Graduate Education

Use separate sheet if necessary

Name of Program and/or School

City State From _____
Month/Year

Credentials/Degrees Awarded To _____
Month/Year

Name of Program and/or School

City State From _____
Month/Year

Credentials/Degrees Awarded To _____
Month/Year

4. Technical/Professional

Name of Program and/or School

City State From _____
Month/Year

Credentials/Degrees Awarded To _____
Month/Year

5. Additional Training/Certifications

Program/ Location/ Date Taken/ Date Expires

i.e. ACLS, BCLS, ATLS, PALS

C. Professional Experience – Medical (Employee/Volunteer)

List all employment in chronological order. Include physicians, group practices, clinics, hospitals, corporations, military, or government agencies where you served in a professional health care capacity. Attach additional sheets if needed.

Employer	Address	Dept/Supvr.	Position	Dates From/To
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D. Other Experience – Non medical (Employee/Volunteer) List in chronological order and identify whether paid or volunteer. Attach additional sheets if needed.

E. Military Experience

Branch _____

Date of Service _____

Rank _____

Experience & Duties _____

F. Professional Affiliations

List below all memberships in professional organizations or societies (local, state, or national). Attach additional sheets if needed.

Name of Organization	Location	Inclusive date From/To	Office Held/ Committee Work
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G. Personal Health

Do you have any medical condition that impairs your ability to perform the essential functions of the position? Yes No

If yes, provide a full explanation of details on a separate sheet and attach.

H. Employment, Hospital, Institutional Actions

1. Have you ever been the subject of a hospital or institution disciplinary proceeding? Yes No
2. At the request of a hospital or institution, have you ever voluntarily agreed to a modification or termination of your privileges? Yes No
3. Have you ever had employment, appointments, or privileges in a hospital or institution suspended, restricted once granted, or revoked? Yes No

Government Actions

1. Has any government agency ever placed you on probation, suspended, revoked, taken any other action against your practice license? Yes No
2. Have you ever been convicted of a crime? List all convictions on a separate sheet of paper. Yes No
3. Have you ever had your DEA registration revoked? Yes No

Professional Society Actions

1. Have you ever been subject to a medical or professional society disciplinary proceeding or review? Yes No

2. Has your membership in any professional organization been suspended or revoked?

Yes No

Other Professional Conduct Actions

1. Have you ever been subject to disciplinary proceedings or to a review affecting your participation in a foundation, HMO, PPO, IPA, Medicare, Medicaid, or similar entity or have you ever been notified of an intent to pursue such actions?

Yes No

Please answer YES or NO to all the above. If yes to any of the above, you will need to provide us with a full explanation of details on a separate sheet and attach.

Applicant's Affidavit

I certify that the information contained in this application is correct to the best of my knowledge. I authorize investigation of all matters contained in this application and agree that any misleading or false statements would be cause for rejection of this application or would be sufficient cause for dismissal if Montefiore Medical Center (MMC) employs me. I understand that my employment is contingent upon satisfactory completion of: a post-offer physical examination by the Occupational Health Service; the receipt of satisfactory work references; and my satisfactory completion of the probationary period. I hereby authorize my present/past employers to furnish MMC with their records of my service. If employed, I authorize MMC to conduct any and all verifications as permitted by federal, state, and municipal codes and regulations. I hereby agree to abide by all MMC rules and regulations. I understand that my employment is not governed by any written or oral contract and is considered an "at will" arrangement. This means that I am free, as is Montefiore, to terminate the employment relationship for any or no reason, as long as there is no violation of applicable federal, state or local law.

NAME: _____

DATE: _____

SIGNATURE: _____

In an effort to define the best way to reach prospective applicants, can you please inform us of how you found out about the Montefiore Postgraduate Residency in Surgery for Physician Assistants?
