College of Osteopathic Medicine
GERIATRIC FELLOWSHIP APPLICATION

Please note: A residency position is contingent upon recommendation by the department chair and approval by the dean as well as meeting the standards of credentialing.

DEMOGRAPHIC DATA:
Name: _____
(L,ast name) (First name) (Middle initial)
LIST ALL DEGREES: _____DO, MA, BA
_____

RESIDENCE ADDRESS
STREET _____
CITY _____
ZIP CODE: _____

TELEPHONE: _____ FAX: _____
EMAIL ADDRESS: _____

IDENTIFICATION NUMBERS (if available):
Social Security Number: _____ Federal Tax ID # _____
Medicare Provider # _____ Medicaid Provider # _____
Medipass # _____ DEA # _____
FL Professional License # _____ Other State License # _____
SPECIALTY(IES): _____
AREA OF CERTIFICATION(S): _____
SPECIALTY BOARD(S): _____
If not certified are you board eligible? Yes ____ No _____
FELLOWSHIP: (Specialty/Subspecialty-list institution name and dates of training)
_____
_____

Pre - Medical Education
(List all colleges and Universities attended prior to medical school)

Name	Year Graduated	Degree

Medical Education
(List all Medical Schools attended)

Name	Dates of Attendance	Year Graduated/Degree

Comlex/USMLE

Examination Level 1? ___ Yes ____ No ____ N/A Date ____ State _
Examination Level 2? ___ Yes ____ No ____ N/A Date ___ State _
Examination Level 3? ____ Yes ____ No ____ N/A Date __ State _

Post Graduate Experience

Position (s) Held: Hospital/Facility Dates

_____
_____
_____

General Information:

Specialty Interest: ____
_____
Hobbies or Other Interest: _____
Previous Professional or
Business Experience: _____
Post Graduate Commitments: _____

Required References and Supplemental Material – Please list the names and addresses of at least three physician references, one must be from your DME. Have each reference send the recommendation directly to the Program Director.

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____

Felony Statement: Have you ever been charged with or convicted of a crime?
____ Yes ___ No
If Yes please explain, give date, place and nature of each such conviction or plea below:

_____
_____

_____
_____
_____
_____

Has your license to practice medicine or any professional registration (e.g., DEA certificate) in any jurisdiction ever been limited, suspended, or revoked, or is such action pending? _____ No _____Yes*
Were there any prior malpractice actions (claims, suits, or judgments made) filed against you in the past five years in this or any other state? ____ No _____Yes*
Are there any malpractice actions pending against you in this or any other state? ____ No _____ Yes*
Has your membership and/or clinical privileges ever been reduced, suspended, revoked, or not renewed at a health care institution? ____No _____ Yes*
The provision of this information is voluntary and we request it for reporting purposes only. This information will not be used in any discriminatory manner and will only be utilized for reporting purposes.
D.O.B.: ___/___/____ Male: _____ Female: _____
Voluntary Information - Used for statistical purposes.
Ethnicity: ___White (not of Hispanic origin)_ African American (not of Hispanic origin)
Hispanic Origin - American Indian or Alaskan Native - Asian or Pacific Islander
Other: (please specify) _____
I certify I am eligible to work in the United States and my application may be delayed or denied if I am ineligible.
_____Signature of Applicant.

U.S. Citizen: Yes ___ No _____ Resident Alien: Yes_____ No _____ Permanent Resident: _____

I certify that answers given herein are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application as may be necessary in arriving at a decision. I understand that false or misleading information given in my application or interview(s) may result in a failure to approve/renew my residency application or result in further disciplinary action up to and including dismissal from the residency including immediate discharge without recourse.. I am required to abide by all rules, regulations, policies, procedures of the residency site and of the university. I understand that my residency is contingent on successful completion and approval of the credentialing committee. Furthermore, continued employment is contingent upon maintaining the appropriate training license. I hereby authorize any and all employers, agencies, educational institutions, references, licensing boards, insurance carriers to provide such information concerning my history as may be requested.

_____

_____
Signature of applicant Date
Please attach a copy of your professional license, internship certificate, residency certificate, board certification(s) (if applicable), medical license, training license, DEA registration, curriculum vitae, and malpractice certificate.

A certified (official) transcript is required from your health professional school.
NOTE
We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, sexual orientation, or any other legally protected status.
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