Memorial Sloan Kettering Cancer Center

Application for Graduate Staff Appointment

Instructions: Submit completed application with the following:

1. For a full-time position at Memorial Hospital include three original letters of recommendation. At least one letter must be from a Service Chief, Program Director or Department Chairman with whom you most recently have served. Residents rotating to Memorial must provide one current letter of recommendation from current Service Chief, Program Director or Department Chairman. All letters of recommendation must be dated and addressed to the appropriate Memorial Hospital Program Director. "To Whom It May Concern" letters, e-mails or facsimile copies are not acceptable.
2. Verification of Medical Education (contact program coordinator for details) or copy of medical school diploma. Foreign Medical Graduates must attach a copy of their ECFMG certification.
3. Current Curriculum Vitae (CV) must include all positions held from Medical/Dental School to the present, including any positions or programs that were begun but not completed. All time periods must be explained. CV must include date on which it was last revised and must be in mm/yyyy format.
4. Individuals who are not United States Citizens must include a copy of a valid visa, employment authorization or Permanent Resident registration card. If you have not yet applied for a visa, please indicate this clearly.
5. New York State requires all trainees in Non-ACGME-Accredited training programs to obtain a New York State license or limited permit. Trainees in ACGME-Accredited training programs should verify with their Training Program Director as they may be required to obtain licensure. New York State licensed physicians must submit a copy of a valid license and registration. Limited permit holders must submit a copy of their limited permit valid at Memorial Hospital. For more information, please call the GME office at (212) 639-6788.
6. Signed delineation of privileges form.

Program/Position applying for | Program Year

Name (Last) | (First) | (Middle) | Degree(s)

Date of Birth | Country of Birth | US Social Security #

Present Address (IncludeCity, State, Zip Code) | Country

E-mail Address | Telephone number

Business Address | Pager or Beeper number

Permanent Address

Are you authorized to work in the United States? No ☐ Yes ☐ Do you require a visa? No ☐ Yes ☐

Visa Type (if applicable) | Date of Issue | Expiration Date | Application Pending (indicate type)

Optional Information: **Sex**: ☐ Male ☐ Female

Ethnic Group: (Check One) ☐ Hispanic or Latino ☐ Asian ☐ Black or African American ☐ White ☐ American Indian/Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Two or More Races

Languages Read Fluently | Languages Spoken Fluently

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Have you taken the NY State Child Abuse Identification Course? No ☐ Yes ☐ (include copy of certificate)

Have you taken Infection Control in NY State within the past three years? No ☐ Yes ☐ (include copy of certificate)

Identification Numbers:

National Practitioner ID (10 digit #)
(Note: US Social Security # required for application)

Health Commerce System Account
(NY State only)

Medical Licensure / Federal DEA:

Do you currently hold a valid medical license? Yes ☐ No ☐

If Yes, is this a Full License ☐ or Limited Permit ☐ ? (**attach copy**)

State License # Date Issued Date of Last Registration Expiration Date

(attach copy)

Federal DEA Registration # Date Issued Expiration Date

Board Certification:

Name of Specialty Board Certification Date of Certification

Professional Training: *(Spell out names, please do not abbreviate)*

Undergraduate School From: (Mon/Day/Year) To: (Mon/Day/Year) Degree Granted Date Granted

City **State** **(Country, if outside US)**

Graduate School From: (Mon/Day/Year) To: (Mon/Day/Year) Degree Granted Date Granted

City **State** **(Country, if outside US)**

Medical/Dental School From: (Mon/Day/Year) To: (Mon/Day/Year) Degree Granted Date Granted

City **State** **(Country, if outside US)**

Include additional pages, if necessary, to identify <u>all</u> undergraduate, graduate and medical schools attended.

GRADUATES OF FOREIGN MEDICAL SCHOOLS

(Please attach copy of certificate)

ECFMG number Date of Issue

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Graduate Medical Education:

A CV is required with this application. However, you must complete this section as well. For location include city and state (country, if outside of the US). Spell out Institutions, do not abbreviate. Add additional pages if necessary.

APPOINTMENTS: Include type (Internship, Residency or Fellowship). List consecutively beginning with Medical/ Dental School graduation. You must include all positions held and all programs in which you have been enrolled, even if for a short time and even if you did not complete the program or fulfill the requirements of the position.

Position	**Specialty Type**	**Dates Attended (From-To) (Mon/Day/Year - Mon/Day/Year)**
Institution Name:	City, State, Country (if outside of the US)	

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Institution Name:	City, State, Country (if outside of the US)	

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Institution Name:	City, State, Country (if outside of the US)	

Initials:__________ Update Date: __________

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All Other Employment or Activities:

Please list all other employment or activities held from the date of your Medical/Dental School graduation.
All gaps in training must be explained. Include time spent studying for exams.

Activity	Dates (From-To) (Mon/Day/Year - Mon/Day/Year)
Institution Name (if applicable):	City, State, Country

Activity	Dates (From-To) (Mon/Day/Year - Mon/Day/Year)
Institution Name (if applicable):	City, State, Country

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Initials:__________ Update Date: __________

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IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS YOU MUST ATTACH A FULL EXPLANATION TO THIS APPLICATION.

1. **Have you ever had any disciplinary or remedial action or investigation taken against you by any state or regulatory agency, administrative body or professional organization in connection with your practice of medicine or participation in a health professions training program? You must include, among other things, any such actions or investigations currently pending and any previous or currently pending charges to professional licensure or registration, (e.g., state or district; Drug Enforcement Administration).**

   Yes ☐ **No** ☐

If the answer to any of the above is "yes", append an explanation including name of body or agency, substance of the allegations, date of investigation or action, findings, and duration of sanction, reasons given by body or agency, and/or reasons for termination of the investigation.

2. **Have you ever been involved as a witness or named as a party in any medical malpractice actions?**

   Yes ☐ **No** ☐

If the answer is "yes", complete the following information for each case and attach additional pages as required to describe the case and your involvement in it.

Full name of case:	Index/File #:
Patient's name:	
Court:	County:
Judgment Amount:	Date Commenced:
Date Completed:	Settlement Amount:
Judgment in Physician's favor: Yes ☐ No ☐	Discontinued ☐
Your involvement:	

3. **Do you have pending against you any medical malpractice actions or are you currently a witness or scheduled to be a witness in any medical malpractice actions?**

   Yes ☐ **No** ☐

If the answer is "yes", complete the following information for each case and attach additional pages as required to describe the case and your involvement in it.

Full name of case:	Index/File #:
Patient's name:	
Court:	County:
Judgment Amount:	Date Commenced:
Description of Case:	
Your involvement:	

4. **Have you ever been convicted of committing an act constituting a crime, including driving under the influence (DUI), or driving while intoxicated (DWI)? You must include any criminal misdemeanor convictions. Attach other pages as necessary to describe the circumstances fully.**

   Yes ☐ **No** ☐ **If yes, attach a full explanation.**

5. **Have you ever voluntarily or involuntarily relinquished your license, registration or certification to practice medicine? You must include any relinquishment of license, registration or certification that occurred during an investigation or under threat of official or institutional proceedings.**

   Yes ☐ **No** ☐ **If yes, attach a full explanation.**

6. **Have you ever voluntarily or involuntarily left, been separated from, or resigned from a training program or medical staff position? You must include here any circumstances in which your participation in a multi-year program or position was ended prior to the end of the complete program or position.**

   Yes ☐ **No** ☐ **If yes, attach a detailed explanation, including the names of persons at your previous institution who can confirm these circumstances**.

7. **Have you ever voluntarily or involuntarily agreed to a limitation or reduction of your clinical privileges at another hospital, health care facility or in relation to a health professions training program?**

   Yes ☐ **No** ☐ **If yes, attach a full explanation, including all circumstances in which you agreed to such limitations or reductions or initiated them yourself.**

8. **Have you ever voluntarily or involuntarily left or resigned, been terminated from or been disciplined at, a job or training position because of inadequate performance, unprofessional conduct or any disruptive or violent behavior?**

   Yes ☐ **No** ☐ **If yes, attach a full explanation.**

9. **Are you currently in the practice of engaging in the unlawful use of drugs or the abuse of alcohol?**

   Yes ☐ **No** ☐ **If yes, attach a full explanation.**

10. **Has your use of prescription drugs, alcohol or other substances ever impaired or limited, or is it currently impairing or limiting, your ability to practice medicine with reasonable skill and safety?**

    Yes ☐ **No** ☐ **If yes, attach a full explanation.**

11. **Do you have any physical or mental condition that prevents you from practicing medicine with reasonable skill and safety?**

    Yes ☐ **No** ☐ **If yes, attach a full explanation.**

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Memorial Hospital for Cancer and Allied Diseases
1275 York Avenue, New York, New York 10065

Declaration and Agreement

I agree to be bound by the bylaws, rules and regulations of Memorial Hospital. I will cooperate with the Hospital in maintaining Joint Commission accreditation and the Hospital Operating Certificate issued under the provisions of the Public Health Law of the State of New York. I will participate in the Hospital's quality assurance and malpractice prevention programs.

I understand that the Center may periodically check government-sponsored databases to ensure that I have not been implicated in any improper practices under Medicare or Medicaid or other third-party programs.

I hereby authorize and consent to the release to Memorial Hospital by any hospital, education institution or other health care facility or individual(s) with which I have or have had an educational or professional affiliation, or by which I have been employed, of any and all information which Memorial Hospital may request in connection with this application, including without limitation, all information required to be requested by New York State law, and hereby release Memorial Hospital, its trustees, officers, agents and employees, and all other individuals and entities, from all civil liability relating to the gathering, review and verification of information made in good faith and without malice relating to my appointment, credentialing and privileging.

To the best of my knowledge, I am not suffering from or undergoing treatment for, any physical or mental condition which impairs my ability to discharge my responsibilities safely and effectively, including in relation to patient care.

I certify that the information contained in this application is correct and complete to the best of my knowledge and belief. I understand and agree that omission or misrepresentation of facts called for on this application or in the appointment process will be cause for rejection of this application or dismissal after I have been appointed. All information submitted by me in this application is true and complete to my best knowledge and belief.

I acknowledge that **it is my responsibility to update these forms** promptly if, and when any information changes, by letter or by memorandum to the appropriate Program Director and to Administrator, Office of Graduate Medical Education, Memorial Hospital for Cancer and Allied Diseases, Box 187, 1275 York Avenue, NY, NY 10065.

Signature_____ Date_____

Name _____

Read and review this submission carefully for accuracy and completeness.

Please print document, sign and date this page, and return completed application to the appropriate Program Director or Coordinator.