**MJHS FELLOWSHIP IN HOSPICE AND PALLIATIVE MEDICINE**

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| **BASIC INFORMATION** | | | | | | | | | | | | | | | | |
| First Name | | Middle Name | | | | | Last Name | | | | | Other/Former/Maiden Name(s) | | | | |
| Street Address | | | | | | Apt # | City | | | | State | Country | | | | Zip Code |
| Home Phone Number | | | | Mobile Phone Number | | | | | | | E-mail Address | | | | | |
| Emergency Contact Name | | | | Relationship to Applicant | | | | | | | Emergency Contact Phone Number | | | | | |
| United States Military Service  Branch From To | | | | | | | | Do you have any relatives who work at MJHS?  Yes; Name(s): No | | | | | | | | |
| National Provider Identifier (NPI)**\*** | New York State License Number | | | | | | | Drug Enforcement Administration (DEA) ID | | | | | | NYS Health Commerce System ID**\*** | | |
| Do you have a legal right to work in the United States?  Yes No | Ethnicity | | | | | | | Specialty | | | | | |  | | |
| **\*** It is Mandatory that ALL fellows have a National Provider Identifier Number, DEA, NYS LIC#, an active New York State Health Commerce System (“HCS”) Account. | | | | | | | | | | | | | | | | |
| **TRAINING POSITION** | | | | | | | | | | | | | | | | |
| Proposed Training Program (Specialty) | | | | | | | | | | | | | | | Postgraduate (PGY) Level | |
| Proposed Start Date **/ /** | | | | |  | | | | | | | | | | | |
| **EDUCATION HISTORY**  ***(including undergraduate study and medical school; continue on a separate page if needed)*** | | | | | | | | | | | | | | | | |
| Institution Name/Location | | | | | | | | | | Dates Attended | | | | | Degree, Honors, Awards | |
|  | | | | | | | | | | *to* | | | | |  | |
|  | | | | | | | | | | *to* | | | | |  | |
|  | | | | | | | | | | *to* | | | | |  | |
| **PREVIOUS EXPERIENCE**  ***(including any previous GME training and medical staff appointments; continue on a separate page if needed)*** | | | | | | | | | | | | | | | | |
| Institution Name/Location/Department | | | | | | | | | | Dates Appointed | | | | | Title | |
|  | | | | | | | | | | *to* | | | | |  | |
|  | | | | | | | | | | *to* | | | | |  | |
|  | | | | | | | | | | *to* | | | | |  | |
| **BOARD CERTIFICATION** | | | | | | | | | | | | | | | | |
| Specialty | | | Certifying Organization | | | | | | Year of Certification | | | | Renewal Year | | | |
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**Fellowship Application**

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| --- | --- | --- |
| **CONFIDENTIAL PROFESSIONAL INFORMATION** | | |
| You have an obligation to disclose all information that may be in any way relevant to an evaluation of your application. Failure to fully disclose any potentially relevant information whether or not specifically called for in this Section, may lead to denial or loss of graduate medical education appointment. The following table is designed to assist you in determining what information is required to ensure a complete disclosure. | | |
| **I. Entities** | **II. Actions** | |
| * Government Agency including: Federal, State, Local, DEA, Office of Professional Medical Conduct, Department of Education, Department of Health * Hospital or other health care facility * Practice Group including: PC, LLC, Partnership * Residency Review Committee * American Medical Association or other Professional Organization * Payers including: Managed Care Plans, Medicare, Medicaid * Specialty Boards | * Censure * Termination * Suspension (regardless of whether it was stayed) * Reduction or Restriction of Privileges or Coverage (voluntary or involuntary) * Probation * Warning * Denial of Licensure, Certification or Completion * Supervision * Monitoring * Reprimand * Counseling * Pending Investigation | |
| * Law Enforcement Entity | * Conviction for any crime (other than a minor traffic offense) * Unresolved arrests * Pending criminal charges or hearings | |
| 1. Have any of the entities described in column I above taken any of the actions listed in column II? | | 🞏 Yes 🞏 No |
| 2. Is there any additional relevant information which is not specifically called for in the table but which in your best judgment is relevant to your  application? | | 🞏 Yes 🞏 No |
| 3. Have you been convicted of any crime related to your clinical practice, including crimes involving Medicare or Medicaid? | | 🞏 Yes 🞏 No |
| 4. Have you been subjected to civil penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid? | | 🞏 Yes 🞏 No |
| 5. Have you been reprimanded or censured by a public regulatory licensing body, a public or private certifying or registering agent, a medical staff or  hospital or other healthcare facility or organization? | | 🞏 Yes 🞏 No |
| 6. Have you been found guilty of professional misconduct as defined by the laws of New York State or any other jurisdiction? | | 🞏 Yes 🞏 No |
| 7. Do you have any criminal convictions; pending criminal matters or hearings; or settlements of criminal matters? | | 🞏 Yes 🞏 No |
| 8. Do you have a medical condition (e.g., psychological or physiological condition or disorder, including substance abuse) that limits or impairs your  ability to practice medicine within the scope of privileges for which you have applied? | | 🞏 Yes 🞏 No |
| 9. Do you use chemical substance- including alcohol, drugs and medications- which in any way impair or limit your ability to practice medicine with  reasonable skill and safety? | | 🞏 Yes 🞏 No |
| 10. Are you currently using illegal drugs? | | 🞏 Yes 🞏 No |
| 11. Have you ever been in a supervised rehabilitation program, professional assistance program, or under the care of a physician or other professional  for monitoring to ensure that you are not habitually using substances that could limit or impair your ability to exercise your privileges appropriately,  or are you currently in such a program or receiving such are? | | 🞏 Yes 🞏 No |
| 12. Have there been, or are there currently pending any medical, dental, or podiatric misconduct or malpractice claims, suits or settlements or  arbitration proceedings in New York or any other state in which you are involved? | | 🞏 Yes 🞏 No |
| 13. Are there any previously successful or currently pending challenges to any licensure or registration (state or district, DEA) or the voluntary  relinquishment of such licensure or registration? | | 🞏 Yes 🞏 No |
| 14. Has there been any voluntary or involuntary termination of residency training or voluntary or involuntary limitation, reduction or loss of clinical  privileges at another hospital or training program? | | 🞏 Yes 🞏 No |
| 15. Has the New York State Department of Health or its Office of Health Systems Management ever made a finding that you violated a patient’s rights? | | 🞏 Yes 🞏 No |
| **If the answer to any of the above questions is “yes”, please provide a detailed explanation on a separate page.** | |  |

**CONDITIONS FOR APPLICATION**

By submitting this MJHS Fellowship Application (“Application”) for appointment as a member of MJHS, I hereby:

* agree to the release of information contained in my Application for purposes of applying to its fellowship training program. The information to be released includes, but is not limited to, copies of relevant registrations, certifications, diplomas, and evaluations.
* understand and agree that I, as an applicant, have the responsibility of producing adequate information for proper evaluation of my qualifications and/or resolution of any doubts about such qualifications. I agree to cooperate fully with any quality assurance, risk management or peer-review investigation undertaken by MJHS.
* verify that the information I provide in this Application is true, accurate and complete. I authorize MJHS to investigate any or all statements I have made in this Application and to seek from third parties—including but not limited to hospitals, medical practitioners, schools, insurers and state agencies—verification of the information I have provided. I understand that any omissions, errors, fraudulent statements or intentional misrepresentations in this application are grounds for termination of appointment or other actions as determined by MJHS.
* waive any confidentiality provisions concerning the information to be provided by third parties and their employees or agents to MJHS in connection with this application, and release such third parties, their employees, or agents from any liability whatsoever for providing such information, provided that such information is provided in good faith and without malice for the purpose of this application.
* waive any confidentiality provisions and release MJHS, their trustees, officers, employees and agents from any liability whatsoever for providing any information contained herein or in my academic files when such information is provided in good faith and without malice and upon request of an authorized representative of any other healthcare facility or any other individual or organization authorized to request such information pursuant to applicable federal, state or local law.

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**Signature** **Date**

**Printed Name**