OSS Health

Application for Employment/Fellowship

Name____ **SS#**________________
Last **First** **MI**

Address____
Street **City** **State** **Zip Code**

Telephone# ( )__________**Cell # ( )**_________ **Work #( )**_______________

E-mail Address___________

Which is the preferred contact?______________

Please include the following items with this application:

A. Curriculum Vitae
B. At least three letters of recommendation
   (One must be from your residency Program Director.)
C. Personal Statement
D. Cover Letter. Please include the month and year in which you are interested in starting
E. A picture to attach to your file; jpeg format if emailed

Confidential Information:

If you have any "yes" answers to any questions in the sections below or those on the following pages, please reference the questions on a separate sheet, give full details and attach.

Have any of the following at any time been, or are they currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other state?

Medical or professional license Yes:___ No:___

DEA or CDS/BNDD registration Yes:___ No:___

Hospital medical staff membership Yes:___ No:___

Clinical privileges or other rights on any hospital staff Yes:___ No:___

Employment by any hospital, institution, or the military Yes:___ No:___

Professional society memberships Yes:___ No:___

Participation in any private, federal or state health insurance program Yes:___ No:___

Participation in an HMO, PPO, or any other managed care program Yes:___ No:___

Board Certification Yes:___ No:___

Have you ever either voluntarily or involuntarily:

Withdrawn your application for medical staff membership at any facility? Yes:___ No:___

Withdrawn your request for any clinical privileges at any facility? Yes:___ No:___

Health Status

Are you able to perform the professional duties of the position with reasonable accommodation? Yes:___ No:___

Are you currently using illegal substances or illegally using substances? Yes:___ No:___

Professional Liability History

In the past 10 years, has your liability insurance ever been canceled or denied? Yes:___ No:___

Do you have any malpractice judgments against you including arbitration in the last 10 years? Yes:___ No:___

Have you had any claim settlements not involving litigation or arbitration paid by you or on your behalf in the last 10 years? Yes:___ No:___

Are you now a defendant in a pending malpractice suit? Yes:___ No: __

At any time, have you ever been

Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of trial, or an accelerated rehabilitation disposition in the disposition of felony charges in any state, territory or country? Yes:___ No:___

Have you ever at any time or are you currently:

Under indictment for any crime? Yes:___ No:___

The subject of an investigation by any private, federal or state health insurance program or state licensing board? Yes:___ No:___

Under investigation by any state licensing board or federal agency? Yes:___ No:___

The subject of any adverse action reports to a state or federal databank? Yes:___ No:___

If you are not a U.S. citizen, do you have authorization to work in the US? Yes:___ No:___

Are you legally eligible for employment in this country? Yes____ No____

Have you ever been bonded? Yes____ No____

Answering "yes" to the following question does not constitute an automatic bar to employment. Factors such as date of the offense, seriousness and nature of the violation, rehabilitation and position applied for will be taken into account.

Have you ever pled "guilty" or "no contest" to or been convicted of a criminal offense or felony? Yes____ No____

If yes, please provide date(s) and details:

____

____

____

____

<u>If the following information is on your CV, you do not need to repeat it here</u>.
<u>However, please initial each page of your CV</u>.

Education and Training

Undergraduate:
Name of School, Address, and Telephone Number:

____
____
____

Degree:_____ Date of Entry:_____ Graduation Date:_____

Medical School:
Name of School, Address, and Telephone Number

____
____
____

Degree:_____ Date of Entry:_____ Graduation Date:_____

International Medical Graduates
ECFMG Number:____________________________ Issue Date:______

Internship:
Name of Institution, Address, and Telephone Number:

____
____
____

Type of Training:_________________
Program Completed: Yes ____ Date:__________ Specialty:_______________
No ____ Explain, if No:_______________________________

Residency:
Name of Institution, Address, and Telephone Number:

____
____
____

Program Completed: Yes:____ Date:_______ Specialty:_______________________
No :____ Explain if no:_________________________________

Residency/Fellowship:
Name of Institution, Address, and Telephone Number:

____
____
____

Program Completed: Yes:____ Date:_______ Specialty:_______________________
No :____ Explain if no:_________________________________

Membership in professional organizations:

If you are licensed, has your license ever been suspended or revoked or are you currently involved in any proceeding that could affect your license or certification?

Yes:____ No:____

States with active (non-training) Licenses:

____
____

Employment History

Starting with your current practice, list all employment since completion of post-graduate training. Explain any gaps in the chronology.

Employer/Practice	Location: Address	Dates: Month/Year
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Hospital Affiliation (Not-Related to Residency Training)

Primary Hospital:______________________ Street Address:________________________
Department: ___________________________ City:_____________ State:___Zip:_____
Staff Category:_______________ Dates of Affiliation:_____________________________

Do you currently admit and care for patients on your own hospital service?
Yes:____No:_____

(Please repeat this for other hospitals, if appropriate)

I attest that all the information I have provided is true, complete and correct.

I authorize Orthopaedic and Spine Specialists, its representatives, employees or agents to contact and obtain information from all references, employers, public agencies, licensing authorities and educational institutions and to otherwise verify the accuracy of all information provided by me in this application.

I understand that any information provided by me that is found to be false, incomplete or misrepresented in any respect, will be sufficient cause to eliminate me from further consideration for employment or may result in my immediate discharge from the employer's service, whenever it is discovered.

Signature of Applicant____

Date:_______________