# YALE-NEW HAVEN HOSPITAL

*Recommendation for Appointment to the Clinical Fellow Staff*

**APPLICANT -- PLEASE COMPLETE THE FOLLOWING:**

**NAME** _____ **REQUESTED START DATE** _____

**SOCIAL SECURITY #** _____

**DATE OF BIRTH** _____ **PLACE OF BIRTH** _____

**DEPARTMENT** _____ **SECTION** _____

**MEDICAL SCHOOL** _____ **YEAR GRADUATED** _____

POSTGRAD.YEAR: _____for year beginning _____(mo/yr), (# years in clinical training since graduation from medical school)

**Fellows Are Not Required To Have A Connecticut Medical License To Practice Within Their Fellowship Program, But To Practice Outside This Training Program, i.e., Moonlighting In The Emergency Room, A Connecticut License Is Required. If You Have A Connecticut License Please Enclose a Copy.**

**DEPARTMENT -- PLEASE COMPLETE THE FOLLOWING:**

**FUNDING SOURCE** _____ **EMPLOYER** _____

**HOSPITAL ADDRESS (Bldg. & Room #)** _____

**HOSPITAL TELEPHONE #:** _____

**HOSPITAL FAX #:** _____

**IS THIS PROGRAM ACGME APPROVED?** _____YES _____NO

**THIS APPLICANT IS A: (Check All Applicable)**

_____ Graduate from a school approved by the Council on Medical Education and Hospitals of the American Medical Association or by the American Dental Association

_____ Foreign medical school graduate who has passed an appropriate qualifying examination.

**ENCLOSE A COPY OF ECFMG CERTIFICATE.**

1. Agency giving examination _____
2. Date of successful completion of examination _____
3. Certificate Number _____

_____ Postdoctoral Fellow

**MALPRACTICE INSURANCE (check one):**

_____ University

_____ Hospital

_____ Other (send copy of Certificate of Insurance to Medical Staff Office).

_____

**Signature of Chief of Department (Not Section Chief)**

**YALE-NEW HAVEN HOSPITAL**
***APPOINTMENT AS CLINICAL FELLOW***

| Last Name | First Name | Middle |
|---|---|---|

**A. DEMOGRAPHICS**

1. Type of Degree:

___ M.D.
___ D.D.S.
___ D.M.D.
___ D.O.
___ Other (specify)

2. Race: In order to comply with various governmental reporting requirements, we must request that applicants for medical staff membership provide information concerning their racial/ethnic background. Please check where appropriate (you may elect not to complete this portion):

___Black ___ Hispanic ___White, Not of Hispanic Origin

___Asian or Pacific Islander ___American Indian/Alaskan Native

___Handicapped ___Vietnam Veteran ___I elect not to complete this portion

3. Gender:

___ Male

___ Female

4. NPI Number _____

**B. ADDRESSES**

1. Home Address (IN CONNECTICUT):

_____

_____
City State Zip

2. Office Addresses (IN CONNECTICUT):

_____

_____
City State Zip

**C. COMMUNICATIONS** (CONNECTICUT INFORMATION ONLY)

1. Home Phone: (_____) _____-_____

2. To whom may your home phone number be released?

__ No One
__ Communications only (Page)
__ Other Physicians only
__ Health Care Professionals
__ Anyone

3. Mobile Phone: (_____) _____-_____

4. Yale Email/Internet: _____
Fax #: (_____) _____-_____

5. Beeper: _____

YNHH Beeper: _____

VA Beeper: _____

Outside Beeper: _____

Instruction on Use of Beeper: _____

**D. MEDICAL LICENSURE/PRACTICE HISTORY INFORMATION**
**If you answer "yes" to any of the following questions, you must supply full details on a separate sheet.**

1. Connecticut State License Number: _____
**(Enclose Copy)**
Expiration Date: _____/_____/_____

2. Regarding your license to practice your profession in any jurisdiction:

| | | | |
|---|---|---|---|
| a. | Has your application ever been denied? | □ Yes | □ No |
| b. | Has your license ever been limited, suspended or revoked? | □ Yes | □ No |
| c. | Has the relevant licensing board ever censured you for matters having to do with professional practice? | □ Yes | □ No |
| d. | Have you entered into a consent order, practice agreement, reinstatement order (or equivalent thereof) with any licensing board? | □ Yes | □ No |
| e. | Have you ever been fined by any licensing board? | □ Yes | □ No |

3. Have you ever been, or are you currently, under investigation or involved in any proceeding involving your practice before any state licensing board? □ Yes □ No

4. Controlled Substance Status:

I am legally allowed to dispense narcotics and have a valid and current DEA number:
__ Yes
__ No

Federal DEA Number: _____ (enclose copy)

Connecticut DEA: _____ (enclose copy)

YNHH DEA: _____ (enclose copy)

5. Have you ever been denied a state or federal certificate of authority to prescribe controlled substances or is your state or federal certificate of authority to prescribe controlled substances currently under investigation? ☐ Yes ☐ No

6. Has your state or federal authority to prescribe controlled substances ever been voluntarily or involuntarily…
   a. limited by the agency? ☐ Yes ☐ No
   b. suspended? ☐ Yes ☐ No
   c. revoked? ☐ Yes ☐ No
   d. denied renewal? ☐ Yes ☐ No

7. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action by any medical organization? ☐ Yes ☐ No

8. Have you ever been sanctioned by a specialty board or has you specialty or sub-specialty certification ever been suspended or revoked? ☐ Yes ☐ No

9. Has your eligibility to participate in the Medicare or Medicaid program ever been suspended or terminate in any state or have you ever been threatened with exclusion or debarment from either program? ☐ Yes ☐ No

10. Have you ever been listed by the OIG (Office of Inspector General) as debarred, excluded or otherwise ineligible for Federal health program participation or otherwise sanctioned by the Federal government, including being listed on the EPLS (Excluded Parties List System)? ☐ Yes ☐ No

11. Have you ever been charged by any local, state, or federal authority, official or agency, plead guilty to or been convicted of any of the following :

    a. crimes or offenses related to the delivery of service under Medicare/Medicaid? ☐ Yes ☐ No

    b. crimes or offenses related to the abuse or neglect of patients in connection with the delivery of health care? ☐ Yes ☐ No

    c. crimes or offenses involving, fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of health care or involving any act or omission in a program financed in whole or in part by any federal, state or local government? ☐ Yes ☐ No

    d. obstruction of justice? ☐ Yes ☐ No

    e. crimes or offenses related to the manufacture, distribution, prescription or dispensing of any controlled substance? ☐ Yes ☐ No

    f. other crimes or offenses (including motor vehicle charges other than parking tickets)? ☐ Yes ☐ No

12. Have you ever been assessed a civil penalty by anyone for false or fraudulent submittal of claims for payment, or other violation of billing practice standards? ☐ Yes ☐ No

13. Have you ever been denied privileges or medical staff membership at any hospital or other health care facility? ☐ Yes ☐ No

14. Have you ever been the subject of disciplinary action and/or a hearing under any set of medical staff bylaws? ☐ Yes ☐ No

15. Have your hospital or other health care facility privileges or medical staff membership ever been voluntarily or involuntarily cancelled, challenged, reduced, surrendered, limited, suspended, not renewed, revoked or withdrawn? □ Yes □ No

16. Are you dependent upon any controlled substance or alcohol? □ Yes □ No

17. Are you currently engaged illegal drug use? □ Yes □ No

18. Do you have any physical, mental or emotional condition that would compromise your ability to practice medicine with reasonable skill and safety? □ Yes □ No

19. Have formal allegations ever been made against you related to any form of impairment, disruptive behavior or unprofessional conduct or have you ever been asked to seek an evaluation or counseling for such behavior? □ Yes □ No

20. Have you ever been reported to the National Practitioner Databank by <u>any</u> individual or organization for <u>any</u> reason? □ Yes □ No

21. Has any malpractice or professional liability claim been brought against you within the past ten (10) years? □ Yes □ No

If yes, please describe on a separate sheet of paper.

22. Have you ever been denied professional liability coverage? □ Yes □ No

**E. BOARD CERTIFICATIONS**

| Specialty Board | Issue Date/Term Date |
|---|---|
| _____ | _____/_____ |
| _____ | _____/_____ |
| _____ | _____/_____ |
| _____ | _____/_____ |

**F. HOSPITAL PRACTICE**

1. Please provide proof of Advance Cardiac Life Support/Basic Life Support certification if you have it. (Not Required)

2. Article V. Section B1. of the Yale-New Haven Hospital Bylaws and the JCAHO mandate that you attest to any health condition that could affect your professional competence. You are also required to report any infectious disease or other conditions which could represent a risk to patients. Do you have any such condition?
   __ No
   __ Yes (please specify)

**G. MEDICAL SCHOOL AFFILIATION**

1. Indicate your primary appointment at YSOM:

| | | | |
|---|---|---|---|
| ___ | No Appointment | __ | Postdoctoral Associate |
| ___ | Postdoctoral Fellow | __ | Clinical Instructor |
| ___ | Lecturer | __ | Assist. Clin. Professor |
| ___ | Research Scientist, Senior | __ | Assoc. Clin. Professor |
| ___ | Research Scientist, Associate | __ | Clinical Professor |
| ___ | Research Scientist, Assistant | | |
| ___ | Instructor | | |
| ___ | Assistant Professor | | |
| ___ | Associate Professor | | |
| ___ | Professor | | |
| ___ | Other (specify) | | |

2. Primary Yale Medical School Department Affiliation:

| | | | |
|---|---|---|---|
| ___ | Anesthesiology | ___ | Neurology |
| ___ | Cell Biology | ___ | Obs/Gyn |
| ___ | Child Study Center | ___ | Ophthal./Vis.Serv. |
| ___ | Comparative Med. | ___ | Ortho/Rehab. |
| ___ | Dermatology | ___ | Pathology |
| ___ | Diagnostic Radiol. | ___ | Pediatrics |
| ___ | Epidem/Publ.Hlth. | ___ | Pharmacology |
| ___ | Human Genetics | ___ | Psychiatry |
| ___ | Intern. Med. | ___ | Psychology |
| ___ | Lab. Med. | ___ | Surgery |
| ___ | Molec.Biophy.& Biochem. | ___ | Therapeutic .Radiology |

Other:
___ Yale Nursing School

3. Other Affiliations with Yale University:
_____
_____
_____

I understand that I cannot submit a bill to Medicare or other payor for services rendered within the scope of my clinical fellow (postdoctoral) training.

I certify that the information provided above is true and complete.

Signature: _____ Date: _____