HOUSE STAFF/FELLOW APPLICATION

Parkland Health & Hospital System ● House Staff & Graduate Medical Education Office ● 5201 Harry Hines Blvd. ● Dallas, Texas 75235 ● Office (214)590-8058 ● Fax (214)590-2776 ●Visit our website at: www.pmh.org

The following information is provided to assist you in completing the House Staff/Fellow Application and to provide other information concerning possible House Staff employment at Parkland Health & Hospital System. All information must be completed even if a resume is attached. Incomplete and/or unsigned applications will not be considered for credentialing.

Please type or print all information.

As part of credentialing, you will be required to submit documents which confirm your eligibility to work in the United States.

"An Equal Employment Opportunity Employer"

Rotator from: (if applicable)

Have you ever worked at Parkland prior to internship/residency? (If yes, when?)

Legal Last Name	Legal First Name	Middle Initial	Title (MD, DO, DDS, etc.)

Maiden Name as applicable	Birth Date ___/___/___ (month / day / year)	Gender: ☐ Male ☐ Female Place of Birth

Marital Status	Spouse name as applicable

Social Security Number	Home Phone	Message Phone/Pager	E-mail
___ - ___ - ___	( )	( )	

Ethnicity: ☐☐				
	(01) Black	(02) Native American	(03) White (non-Hispanic)	(04) Asian/Pacific Islander
	(05) Middle Eastern	(06) Hispanic (__________)	(10) Other (__________)	

Citizenship Status:

☐ US Citizen (Born) ☐ US Citizen (Naturalized) ☐ US Citizen (Born on an Army base)
☐ Permanent Resident (attach copy of Resident Alien card) ☐ J-1 (attach copy of DS2019, Passport and I-94)
☐ H1B (attach copy of DS2019, Passport and I-94)

Please list other foreign language skills:

Language ______________ ☐ Speak ☐ Read ☐ Write
Language ______________ ☐ Speak ☐ Read ☐ Write

Are you a,

☐ US or Non-US Graduate of Domestic Medical School
☐ Non US Foreign Medical School

CONTACT INFORMATION

Current Home Address (Number and Street)	Apt.#	City	State	Zip

Home Telephone:	Pager

EMERGENCY CONTACT

Person to contact in Case of Emergency: (Please list someone.) Name:	Relationship:

Current Address (Number and Street)	Apt.#	City	State	Zip

Home Telephone:	Pager

EDUCATION (MEDICAL/DENTAL)

Medical/Dental School Name

Mailing Address ((Number and Street) City State Zip

Dates Attended:

From : ____/____/________ To : ____/____/________
month day year month day year

Graduation Date

____/____/________
month day year

Degree Received: ☐ MD ☐ DO ☐ MDM ☐ DDS ☐ DDSMD

CURRENT AND/OR PRIOR TRAINING (INTERNSHIP/RESIDENCIES/FELLOWSHIP/PRIVATE PRACTICE/RESEARCH)

Please provide below a chronological list of training and work history since graduating medical/dental school. If there are any periods of more than three months unaccounted for since your graduation from medical/dental school, please attach a separate sheet explaining your activities during those times.

Institution:

Mailing Address ((Number and Street) City State Zip

Dates Attended:

From : ____/____/________ To : ____/____/________
month day year month day year

Specialty:

☐ Internship ☐ Residency
☐ Fellowship ☐ Other___________

Was the program successfully completed? ☐ Yes ☐ No

Institution:

Mailing Address ((Number and Street) City State Zip

Dates Attended:

From : ____/____/________ To : ____/____/________
month day year month day year

Specialty:

☐ Internship ☐ Residency
☐ Fellowship ☐ Other___________

Was the program successfully completed? ☐ Yes ☐ No

Affiliation (Hospital/Healthcare):

Mailing Address ((Number and Street) City State Zip

Dates Attended:

From : ____/____/________ To : ____/____/________
month day year month day year

Specialty:

☐ Internship ☐ Residency
☐ Fellowship ☐ Other___________

Was the program successfully completed? ☐ Yes ☐ No

U.S. MILITARY SERVICE

Have you served in the Armed Services? ☐ Yes ☐ No | If yes, indicate date of service: to

Branch:

Please attach a copy of your DD214 form. (if applicable)

LICENSURE

If you are an International Medical Graduate, are you: ECFMG Certified? ☐ Yes ☐ No ☐ N/A

ECFMG No.: _____-______________-________-______ ECFMG Issue Date: ____/____/________
month day year

PLEASE INCLUDE A COPY OF THE FOLLOWING WITH THIS APPLICATION: (if applicable)		
☐ Current Full Texas Medial License	☐ Attached	☐ N/A
☐ Controlled Substances Registration Certification (DPS)	☐ Attached	☐ N/A
☐ Current Federal DEA Registration	☐ Attached	☐ N/A

If you are a resident who is doing a <u>rotation</u> at Parkland from <u>another institution</u> and you are currently working under a "Physician In Training Permit" issued by the Texas Medical Board, please submit a copy. ☐ Attached

OTHER BACKGROUND INFOMATION

If you answer "Yes" to any of the following questions, please provide details on a separate sheet of paper. Include copy of any order or settlement where applicable.

Question	Answer
1. Have you ever been denied a professional license, resident permit, or certification by any licensing or certifying board or agency and/or are there any actions, proceedings or investigations, past or pending, related to your license, permit or certification?	☐ Yes ☐ No
2. Have you ever voluntarily or involuntarily relinquished your State or Federal controlled substance registration or have you ever been the subject of any disciplinary action or proceeding brought by any State or Federal licensing or regulatory agency (including State or Federal controlled substance registration), or board including, but not limited to, reprimands, probation, monitoring (other than routine), limitation of practice or procedures or mandatory second opinions?	☐ Yes ☐ No
3. Have you ever received notice of termination or been sanctioned, monitored (excluding random monitoring), or excluded from status as a supplier of services under the Medicare, Medicaid, CLIA, Champus or any other Federal or State government programs?	☐ Yes ☐ No
4. Have you ever been convicted of a felony or misdemeanor; or have you received probation or deferred adjudication; or are any charges pending against you at this time?	☐ Yes ☐ No
5. Do you have a physical or mental condition, which in any way could impair your ability to practice medicine or in any way poses a potential or actual risk or harm to your patients?	☐ Yes ☐ No
6. Have you ever been affected by or sought counseling or treatment for drug use, chemical or alcohol dependency or behavioral problems?	☐ Yes ☐ No
7. Are you currently taking any medication, which could affect your clinical judgment or motor skills?	☐ Yes ☐ No

I authorize Parkland Health & Hospital System, employees and agents ("PHHS") to consult with hospitals, members of hospital medical staffs, professional liability carriers, and other persons or entities to obtain information concerning my qualifications, including without limitation, my professional competence and conduct. I authorize and consent to the release to PHHS of any and all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions and information that might otherwise be considered confidential or privileged.

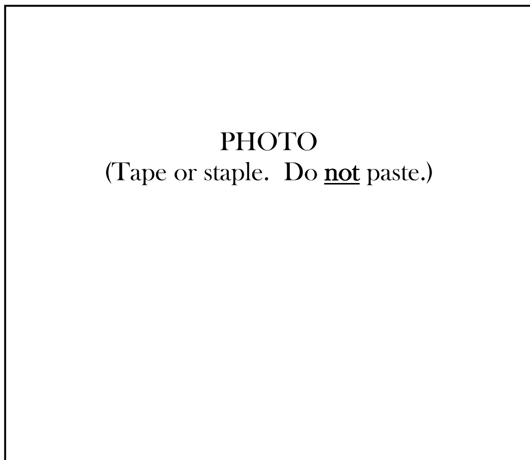
I release from Liability PHHS and all PHHS officers, directors, agents, representatives and employees, including PHHS house staff and credentialing staff, for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications, and I release PHHS and its officers, directors, agents, representatives and employees, and any and all persons, hospitals, organizations or health care entities providing information about me to PHHS without limitation, from any and all liability connected with or arising from the release of such information, provided that such person(s), hospital(s), organization(s) or health care entity(ies) was acting in good faith and without malice. I further release PHHS and its officers, directors, agents, representatives and employees from any and all liability for its acts performed in good faith and without malice in evaluating my application and any decisions related to my application or status.

I understand and agree that any misstatement or failure to disclose information in this application which may be considered relevant in the credentialing evaluation process, the ultimate credentialing determination or any re-credentialing process will constitute grounds for rejection of my application. If any material changes occur in the information I have provided in this application making such information no longer correct and complete, I understand and agree that it is my obligation to notify PHHS or its designee within ten (10) days of said occurrence. Failure to comply with this obligation may constitute grounds for rejection of my application or immediate termination.

By my signature, I attest that the information contained in this application is true, correct and complete.

Signature: ______________________________ Date: ____________________

Printed Name: ______________________________



Applicant Disclosure

Pursuant to the requirements of the Fair Credit Reporting Act, notice is given that a consumer report* may be made in connection with your application for employment.

If you are denied employment, either wholly or partly, because of information contained in a consumer report a disclosure will be made to you of the name and address of the report and a statement of your consumer rights.

By signing below you consent to the procurement of a consumer report* in connection with your application for employment and/or continued employment.

Today's Date: ____

Applicant's Signature: ____

Applicant's (printed) Name: ____

Applicant's Other Last Name(s): ____

Social Security Number: ____

*Date of Birth: ____

**for consumer report purposes only*

Driver's License #: ____________________________ State ________

Please list previous and current city and states in which you have lived.

1) ____

City, State

2) ____

City, State

3) ____

City, State

4) ____

City, State

* A consumer report may consist of employment records, educational verification, licensure verification, driving history, previous addresses, and other public records relative to criminal charges. A credit report will not be requested unless it is deemed pertinent to the functions of the position for which you are applying.