



**EDUCATION AND SKILLS**

**High School** \_\_\_\_\_ **City & State** \_\_\_\_\_  
**Year Graduated or Highest Grade Completed** \_\_\_\_\_

| Colleges and Universities Attended | City and State | Years Attended |    | Major and Minor Subjects | Degree and Year Granted |
|------------------------------------|----------------|----------------|----|--------------------------|-------------------------|
|                                    |                | From           | To |                          |                         |
| Undergraduate Education            |                |                |    |                          |                         |
|                                    |                |                |    |                          |                         |
| Graduate Education                 |                |                |    |                          |                         |
| Residency/Postgraduate Training    |                |                |    |                          |                         |
|                                    |                |                |    |                          |                         |

List any other courses, studies of training leading to certificate, diploma, or degree:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**LICENSES/CERTIFICATIONS/SPECIALTIES**

List all current and past licenses:

| State | License No. | Date Issued |  | Expiration Date | Status |
|-------|-------------|-------------|--|-----------------|--------|
|       |             |             |  |                 |        |
|       |             |             |  |                 |        |
|       |             |             |  |                 |        |
|       |             |             |  |                 |        |
|       |             |             |  |                 |        |

If the answer to any of the following questions is YES, please provide details on a separate sheet.

- Have proceedings ever been instituted to have your license to practice medicine limited, suspended, revoked, denied, or subject to probationary conditions?  Yes  No
- Have proceedings ever been instituted to have your DEA license or other controlled substance authorization denied, revoked, or suspended?  Yes  No
- Have proceedings ever been instituted to have your specialty board certification denied, revoked or suspended?  Yes  No
- Have you ever been a defendant in a criminal proceeding related to the practice of medicine?  Yes  No

**Licensure Exam:**

National Board No.:  
 USMLE No.:  
 Flex No.:  
 State Board No.:

If foreign medical graduate, ECFMG No.:

**(If a Foreign Medical Graduate, ECFMG certificate is to be submitted to the department)**

Have you been convicted of a crime or released from prison within the last seven- (7) years?  Yes  No

If yes, describe in full, including date(s):

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Federal DEA Registration No. \_\_\_\_\_ Dated Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**SPECIALTY BOARD CERTIFICATION (S)**

| Specialty | Certification Date | Expiration Date | Re-Certification Date |
|-----------|--------------------|-----------------|-----------------------|
|           |                    |                 |                       |
|           |                    |                 |                       |
|           |                    |                 |                       |

If not certified, state your intent with respect to becoming certified and describe the status of your efforts and eligibility, including pas efforts and failures of written or oral exams, if any:

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Please provide all hospital affiliations, employers and locum tenens.

**FORMAL CLINICAL TEACHING EXPERIENCE**

| Name and Location of School | Rank and/or Title | Teaching Field | Years |    | Salary |
|-----------------------------|-------------------|----------------|-------|----|--------|
|                             |                   |                | From  | To |        |
|                             |                   |                |       |    |        |
|                             |                   |                |       |    |        |
|                             |                   |                |       |    |        |
|                             |                   |                |       |    |        |
|                             |                   |                |       |    |        |

**EXPERIENCE OTHER THAN TEACHING**

| Position | Employer | Address | Years | Salary |
|----------|----------|---------|-------|--------|
|          |          |         |       |        |
|          |          |         |       |        |
|          |          |         |       |        |
|          |          |         |       |        |
|          |          |         |       |        |

**CURRENT CLINICAL PRIVILEGES**

| Name of Institution | Location (address) | Appointment |
|---------------------|--------------------|-------------|
|                     |                    |             |
|                     |                    |             |
|                     |                    |             |
|                     |                    |             |

**REQUEST FOR MSM STAFF CATEGORY AND STAFF PRIVILEGES**

The Applicant requests that privileges be delineated in the following field(s):

1. \_\_\_\_\_
2. \_\_\_\_\_

The Applicant desires the following specific clinical privilege(s):

- |          |           |
|----------|-----------|
| 1. _____ | 2. _____  |
| 3. _____ | 4. _____  |
| 5. _____ | 6. _____  |
| 7. _____ | 8. _____  |
| 9. _____ | 10. _____ |

**List equipment on which you have been trained to perform special medical procedures.**

| Equipment | Date Certified | No. of Procedures |
|-----------|----------------|-------------------|
|           |                |                   |
|           |                |                   |
|           |                |                   |
|           |                |                   |

**CHRONOLOGICAL PROFESSIONAL HISTORY**

**If the answer to any of the following questions is YES, please provide full details on a separate sheet.**

- A. Have your clinical privileges at any hospital or healthcare institution been limited, suspended, revoked, not renewed, or subject to probationary conditions, or have proceedings toward any of those ends been instituted or recommended by a medical staff official or committee or governing board?  Yes  No
- B. Have your medical staff membership of medical staff status at any hospital or healthcare institution been limited, suspended, revoked, not renewed, or subject to probationary conditions, or have proceedings toward any of those ends been instituted or recommended by a medical staff official or committee or governing board?  Yes  No
- C. Have you been denied membership on any hospital medical staff, or advancement in medical staff status, or has such a denial been recommended by a medical staff official or committee or governing board?  Yes  No
- D. Has your request for any specific clinical privilege(s) been denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship) or has such a denial or limitation been recommended by a medical staff official or committee or governing board?  Yes  No
- E. Have you voluntarily relinquished any medical staff membership, or clinical privilege(s) while under investigation or disciplinary action?  Yes  No

**PROFESSIONAL LIABILITY HISTORY**

If the answer to any of the following questions is YES, please provide full details on a separate sheet.

1. Have you ever practiced medicine without liability coverage?  Yes  No
2. Have you ever been denied professional liability insurance or has your policy ever been cancelled or denied renewal?  Yes  No
3. Have you ever been a defendant in a malpractice/professional liability suit, or have you ever received written notice of intent to file such a suit?  Yes  No

List **ALL** insurance carriers (including insurance companies, hospitals, clinics, employers, etc.) who have provided professional liability coverage.

|                                   |              |                 |                           |           |
|-----------------------------------|--------------|-----------------|---------------------------|-----------|
| <b>Current Insurance Carrier:</b> |              |                 | <b>From</b>               | <b>To</b> |
| <b>Address</b>                    |              |                 | <b>Policy Number</b>      |           |
| <b>City</b>                       | <b>State</b> | <b>Zip Code</b> | <b>Years with Company</b> |           |

|                           |              |                 |                           |           |
|---------------------------|--------------|-----------------|---------------------------|-----------|
| <b>Insurance Carrier:</b> |              |                 | <b>From</b>               | <b>To</b> |
| <b>Address</b>            |              |                 | <b>Policy Number</b>      |           |
| <b>City</b>               | <b>State</b> | <b>Zip Code</b> | <b>Years with Company</b> |           |

|                           |              |                 |                           |           |
|---------------------------|--------------|-----------------|---------------------------|-----------|
| <b>Insurance Carrier:</b> |              |                 | <b>From</b>               | <b>To</b> |
| <b>Address</b>            |              |                 | <b>Policy Number</b>      |           |
| <b>City</b>               | <b>State</b> | <b>Zip Code</b> | <b>Years with Company</b> |           |

|                           |              |                 |                           |           |
|---------------------------|--------------|-----------------|---------------------------|-----------|
| <b>Insurance Carrier:</b> |              |                 | <b>From</b>               | <b>To</b> |
| <b>Address</b>            |              |                 | <b>Policy Number</b>      |           |
| <b>City</b>               | <b>State</b> | <b>Zip Code</b> | <b>Years with Company</b> |           |

**PROFESSIONAL REFERENCES**

List individuals other than those listed elsewhere in this application who have observed your clinical performance during a recent period.

|                |              |                 |                                  |  |
|----------------|--------------|-----------------|----------------------------------|--|
| <b>Name</b>    |              |                 | <b>Professional Relationship</b> |  |
| <b>Address</b> |              |                 | <b>Length of Relationship</b>    |  |
| <b>City</b>    | <b>State</b> | <b>Zip Code</b> | <b>Phone Number</b>              |  |

|                |              |                 |                                  |  |
|----------------|--------------|-----------------|----------------------------------|--|
| <b>Name</b>    |              |                 | <b>Professional Relationship</b> |  |
| <b>Address</b> |              |                 | <b>Length of Relationship</b>    |  |
| <b>City</b>    | <b>State</b> | <b>Zip Code</b> | <b>Phone Number</b>              |  |

|                |              |                 |                                  |
|----------------|--------------|-----------------|----------------------------------|
| <b>Name</b>    |              |                 | <b>Professional Relationship</b> |
| <b>Address</b> |              |                 | <b>Length of Relationship</b>    |
| <b>City</b>    | <b>State</b> | <b>Zip Code</b> | <b>Phone Number</b>              |

|                |              |                 |                                  |
|----------------|--------------|-----------------|----------------------------------|
| <b>Name</b>    |              |                 | <b>Professional Relationship</b> |
| <b>Address</b> |              |                 | <b>Length of Relationship</b>    |
| <b>City</b>    | <b>State</b> | <b>Zip Code</b> | <b>Phone Number</b>              |

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**CONTINUING MEDICAL EDUCATION**

Please provide primary continuing medical education credits for the past two years

| <b>Course Title/Location</b> | <b>Dates</b> | <b>CME Credit Hours</b> |
|------------------------------|--------------|-------------------------|
|                              |              |                         |
|                              |              |                         |
|                              |              |                         |
|                              |              |                         |

**ADVANCED LIFE SUPPORT CERTIFICATION:**

|                       |             |              |                        |              |  |
|-----------------------|-------------|--------------|------------------------|--------------|--|
| <b>Course Sponsor</b> |             |              | <b>Expiration Date</b> |              |  |
| <b>Address</b>        | <b>City</b> | <b>State</b> | <b>Zip Code</b>        | <b>Phone</b> |  |

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**PROFESSIONAL MEMBERSHIPS & ORGANIZATIONS**

| <b>Organization/Location</b> | <b>Dates</b> |
|------------------------------|--------------|
| 1.                           |              |
| 2.                           |              |
| 3.                           |              |
| 4.                           |              |
| 5.                           |              |

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**APPLICANT'S CERTIFICATION**

I fully understand that any misstatements in or omissions from this application may constitute cause for denial of appointment or cause for summary dismissal from the faculty and the medical staff. All information submitted by me in this application is true to my best knowledge and belief.

In making this application for appointment to the Faculty and membership in Morehouse Medical Associates, Inc. (MMA), I agree to abide by the by-laws, rules, and regulations of the Faculty, and MMA, and I further agree to abide by such rules and regulations as may be from time to time enacted. I am familiar with the principles and standards of the Joint Commission on Accreditation of Health Care Organizations and the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty and/or profession, and I agree to be bound by the terms thereof if I am granted membership or clinical privileges, and I further agree to be bound by the terms without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment to the Faculty and to MMA.

By applying for appointment to the Faculty and membership in MMA, I hereby signify my willingness to appear for the interviews in regard to my application, authorize the school, its professional staff and their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the school, its professional staff and its representatives of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my moral and ethical qualifications for membership. I hereby release from liability, all representatives of the school and its professional staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the school, its professional staff, in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

Applicant's Signature \_\_\_\_\_  
(Degree)

Date \_\_\_\_\_



**MOREHOUSE SCHOOL OF MEDICINE**

**(PLEASE ANSWER ALL QUESTIONS – PLEASE PRINT)**

**Human Resources**

The Civil Rights Act of 1964 and ADA (Title I) prohibits discrimination in employment with regard to race, color, religion, sex, national origin, age, marital status, physical or mental status, physical or mental handicap, disability or veterans status.

To help Morehouse School comply with Federal/State equal employment opportunity record keeping, reporting and other legal requirements, please answer the questions below.

**Note:** This Pre-employment information form will be kept in a confidential file and will have no bearing on your application.

**APPLICANT: DOCUMENTS WILL NOT BE RETURNED AFTER SUBMITTED**

**Date:**

**Position(s) applying for:** 1) \_\_\_\_\_ 3) \_\_\_\_\_  
2) \_\_\_\_\_ 4) \_\_\_\_\_

**Name:** \_\_\_\_\_  
Last First Middle

**Address:** \_\_\_\_\_  
Number and Street City State Zip Code

**Telephone:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_

**Are you a U.S. Citizen?**  Yes  No **If No, are you authorized to work in this country?**  Yes  No

**If yes, what is your Visa status?**  J-1  HIB  Other \_\_\_\_\_

**Race/Ethnic Group**  Black  White  Hispanic  American Indian  
 Asian  Pacific Islander  Other \_\_\_\_\_

**Sex**  Male  Female **Marital Status**  Single  Married  Divorced  Separated

**Vietnam Era Veteran**  Yes  No **If Yes, what is your Disability rating?**

**Vietnam Veteran**  Yes  No

**\*Employment Eligibility and Identity Documents will be Required at Time of Hire.**



# **MOREHOUSE SCHOOL OF MEDICINE**

Human Resources

## **RELEASE OF INFORMATION (Supplemental to Employment Application)**

### **AN EQUAL OPPORTUNITY EMPLOYER**

I hereby give my consent and authorization to the MOREHOUSE SCHOOL OF MEDICINE and/or its designee to obtain any information, which is relevant to my application for employment. Any person(s) or organization(s) are directed to furnish such information upon request.

This release of information is given with my full knowledge and understanding.

With my signature below, I release any person(s) or organization(s) and their employees, agents and officials, acting in an official capacity, from any liability for complying with this release.

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**APPLICANT'S SIGNATURE**

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**DATE**

**APPLICANT INFORMATION RELEASE**

I hereby authorize Morehouse School of Medicine and/or Vericon Resources, Inc. and/or any of their authorized agents to gather information regarding the following: All records including criminal, credit, driving, drug, and/or education; written or verbal information from previous employers; any other pertinent information relating to the function of my job.

I understand that all inquiries on this form are used for identification purposes only in order to conduct a background check, and are asked for legitimate nondiscriminatory reasons. Responses to sex, age, and race inquiries are voluntary, and choosing not to respond will not preclude hire or promotion. I hereby release Morehouse School of Medicine employees, former employees, other references, and Vericon Resources, Inc. and any of its authorized agents from liability, and understand there is no invasion of privacy.

I understand that submission of false information on this or any employment form may result in non-selection or in termination if hired. The following is my complete legal name, and all information is true and correct to the best of my knowledge. This information is used for verification purposes ONLY:

|   |   |  |  |
|---|---|--|--|
| <b>Last Name, First Name, Middle Initial (PLEASE PRINT LEGIBLY)</b> |   | <b>Position Applying For:</b>              |  |
| <b>Applicant's Signature</b>  |   | <b>Driver's License Number &amp; State</b> |  |
| <b>Social Security Number</b>                                       | <b>Responses to the questions in this section are optional and voluntary, for ID Only</b> |  |  |
| <b>Date of Birth</b>  | <b>Race</b>   | <b>Sex</b>                                 | <b>M <input type="checkbox"/> F <input type="checkbox"/></b> |
| <b>Former Names and Time Frames (if applicable)</b>                 |   |  |  |
| <b>Current Address</b>  | <b>City/State</b>   | <b>Zip/County</b>                          | <b>Dates (Mo/Yr.)</b>  |
| <b>Previous Addresses (Past 7 Years)</b>                            |   |  |  |
|   |   |  |  |
|   |   |  |  |
|   |   |  |  |
|   |   |  |  |
|   |   |  |  |
|   |   |  |  |

**FOR MOREHOUSE SCHOOL OF MEDICINE OFFICE USE ONLY:**

**Please complete the following section:**

|   |                                 |   |
|---|---------------------------------|---|
| <b>Please Check Services Requested:</b> |                                 |   |
| Crim <input type="checkbox"/>           | Credit <input type="checkbox"/> | MVR <input type="checkbox"/>              |
| Drug <input type="checkbox"/>           | Educ <input type="checkbox"/>   | Employ <input type="checkbox"/>           |
| Ref <input type="checkbox"/>            | Other <input type="checkbox"/>  | (specify on fax) <input type="checkbox"/> |
| <b>Contact Name</b>                     | <b>Phone #</b>                  | <b>Date</b>                               |

Phone: 770/457-9922  
800/795-3784  
Fax:800/915-1020

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