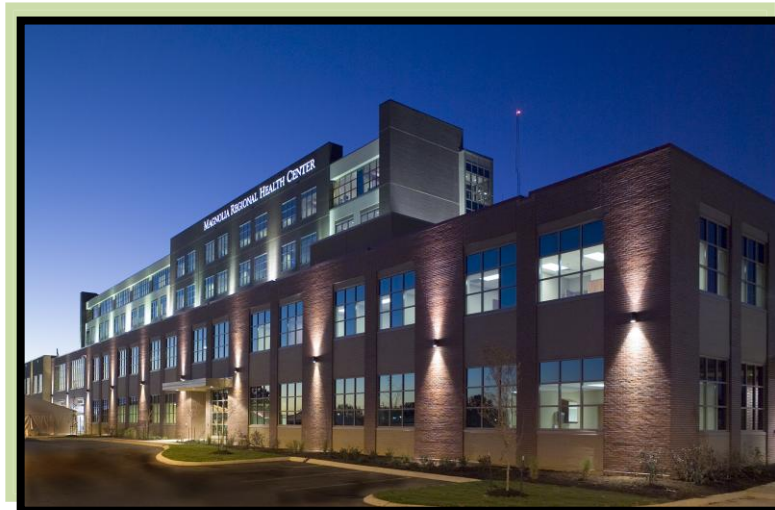




APPLICATION FOR APPOINTMENT

Magnolia Regional Health Center Internal Medicine Residency Program



MEDICAL EDUCATION POST –GRADUATE

1. On a separate sheet, list all postgraduate activities that you have attended or you have received credit in the past twenty four months.
2. Continuing Medical Education activity during the Past FOUR (4) years.
3. Furnish a list of scientific papers or essays you have written and a list of scientific meetings you have attended during the previous three years (include reprints).
4. I have already passed the examinations checked below on the dates indicated:

COMLEX	DATE	SCORE
NBOME, Part I		
NBOME, Part II		
NBOME, Part III		
PE		

5. LICENSING OF ANY TYPE:

License (Name of State and County): _____
 License Number /Date Issued /Expiration Date: _____

MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS & COLLEGES:

AOA Member # _____ ACOI Member # _____
 (Name, office held, if applicable and dates). Please notify the Medical Staff Office if you become a member after filing application.

PHOTO: (Please attach a recent photograph of yourself)

PERSONAL STATEMENT: (Please prepare and attach a personal statement that includes the following:

- 1) A short biographical sketch of yourself.
- 2) Your reason for entering Osteopathic medicine.
- 3) Your expectations for your future practice as an Osteopathic physician.
- 4) Hobbies and/or non-medical interests you have.

HEALTH STATUS:

Present State of Health _____ Date of Last Health Exam _____

Name, address & telephone# of examining physician

*Please indicate whether you are able to perform the essential functions of the profession for which you are seeking privileges, with or without reasonable accommodations. **Yes /No**

REFERENCES: At least three (3) physicians PLUS Dean's letter. Please give complete mailing addresses, including postal zip codes and telephone numbers. (The hospital, at its option may contact references other than those chosen).

Name and Address _____

Telephone: _____

Name and Address _____

Telephone: _____

Name and Address _____

Telephone: _____

Name and Address _____

Telephone: _____

IF EITHER OF THE FOLLOWING IS ANSWERED IN THE AFFIRMATIVE, PROVIDE FULL EXPLANATION ON A SEPARATE SHEET.

1. During the past 10 years, have there been, or are there currently pending any malpractice claims, suits settlements or arbitration proceedings involving your professional practice? Yes No
2. Have you ever been denied Professional Liability Insurance? Yes No

DISCIPLINARY ACTIONS:

3. Have any of the following ever been or are currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? If YES, please provide full explanation on a separate sheet.

Other professional registration/license	Yes	No
Academic appointment	Yes	No
Membership on any hospital medical staff	Yes	No
Clinical Privileges	Yes	No
Other institutional affiliation or status there at	Yes	No
Professional society membership or fellowship/ Board Certification	Yes	No
Professional Office	Yes	No
Any other type of professional sanction	Yes	No
Have there been any felony criminal charges brought against you in the last 5 years?	Yes	No
Have you ever been charged with, convicted of, or treated for alcohol and/or drug abuse?	Yes	No
If there is any other significant information not asked on this application which should be known by the committees evaluating your eligibility for program acceptance, please provide as an attachment.	Yes	No

AUTHORIZATION:

(For background investigation and release of information to Magnolia Regional Health Center).

In making application for program acceptance, I agree to abide by the Bylaws, Rules and Regulations of the Medical Staff and the Hospital; and by such rules and regulations as may be from time to time enacted, provided that I do not abrogate any of my civil rights. Moreover, I hereby declare that I shall not engage in the practice of the division of fees under any guise whatsoever. Further, I certify that I have no physical or mental health impairment that would prevent me from conducting my practice of medicine.

I agree to report any changes in my health status that would affect my ability to practice medicine, any changes in my professional liability insurance coverage, the filing of a lawsuit against me, investigation by licensing board or regulatory agency, any inclusion on any Federal or State exclusion/sanction list, or any change in Medical Staff membership status at any other hospital.

I hereby give permission to the Board of Directors, Hospital Administration, Medical Staff or the designees of each, to make such investigation or review as they deem appropriate into my ability to practice at the level for which I am seeking privileges. I acknowledge that such investigation and review might include, but not limited to a review and investigation of my treatment of patients at this or other hospitals, as well as the status of my health, my credentials, and professional conduct. I agree to assist and cooperate in the investigation and review, and hereby grant permission for it to be conducted. I voluntarily release from liability or responsibility the Magnolia Regional Health Center Board of Directors, Hospital Administration, Medical Staff, and/or their designees, and all persons, places of business, and municipalities providing information in good faith and without malice. A photographic copy of this release is to be considered acceptable as an original.

I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the Residency and Internship Programs at Magnolia Regional Health Center.

All information submitted by me in this application is true to my best knowledge and belief.

Date

Signature of Applicant

FOR OFFICIAL USE ONLY:

Appointment recommended: Y / N Appointment deferred _____

Comments: _____

Date _____ Program Director, Graduate Medical Education

Comments: _____

Date _____ Administrative Director Graduate Medical Education

Comments: _____

Date _____ Chairman, Graduate Medical Education Committee

PLEASE RETURN COMPLETED APPLICATION TO:

GME Department
Magnolia Regional Health Center
611 Alcorn Drive
Corinth, MS 38834

ATTN: Gena Lindsey, RN
Administrative Director GME
and Medical Student Program