Office of Graduate Medical Education
Division of Cardiology
Phone: 662-293-7687 Fax: 662-293-4347

Dear Doctor:

Attached is an application for our Cardiology fellowship program.

Please submit all information to the Office of Medical Education by the stated deadline, to be considered for a slot in our program.

1. Completed application (typed or printed legibly in black ink)
2. Official medical school transcript
3. COMLEX/USMLE Part I, II, and III and AOBIM Board scores
4. Three (3) current letters of recommendation
5. Copy of internship and/or residency certificates
6. Medical School Diploma and Internal Medicine Diploma
7. Personal Statement
8. Copy of any state licensure
9. Copy of the NPI and DEA certifications
10. Certificates of Postgraduate Training
11. Current Malpractice (if applicable)
12. Please include photo, cell number and email contact.
13. Please include a copy of Birth certificate, SS,ACLS, BLS cards and driver's license.

Should you have any questions, please call the GME office at 662-293-7687.

Sincerely,

John Wayne Prather, Ph.D., M.D.,
Magnolia Regional Health Center
Cardiology Fellowship Program Director
Magnolia Regional Health Center
611 Alcorn Drive
Corinth, Ms. 38834

Gena Lindsey, RN, C-TAGME
Designated Institutional Official
Graduate Medical Education
Magnolia Regional Health Center
611 Alcorn Drive
Corinth, Ms. 38834

Please Visit us on the web at www.mrhc.org

APPLICATION FOR APPOINTMENT

Magnolia Regional Health Center Cardiology Fellowship

APPLICATION FOR FELLOWSHIP

Please type OR print legibly.
Provide complete information including street address/zip codes.
Place a response in each blank. Use "N/A" or "NONE" where applicable.
*Requested Supporting documents are highlighted in green and asterisks. Documents provided in ERAS application will not need to be reproduced.

TYPE OF PROGRAM APPLIED FOR: ( )Cardiology Fellowship PGY Year __

Name ______________________________________ Social Security #________________

Last First Middle

Place of Birth: ____ D.O.B.______________

Current Home Address _______________________________________ State______________

Telephone: _______________ Cell #________________ Are you a U.S. citizen? ___________

Alien Registration # ____________________ Expiration Date_________________

**Please provide a copy of your registration if applicable.*
**Please provide a copy of your Driver's License and/or passport*
Please provide a copy of your Birth Certificate. Original and/or notarized copy.

PRE-MEDICAL EDUCATION:
College or University attended: ____

____
Street Address City/State/Zip

____
Degree Obtained / Date Honors

MEDICAL EDUCATION:
Medical School attended: ____

____
Street Address City/State/Zip

____
Degree / Date Honors
***Please provide a copy of your Medical Diploma for your file.**

INTERNSHIP or PREVIOUS RESIDENCY:
Hospital Name____
Street Address City/State/Zip : ____
Type of Internship Specialty – YEAR: ____

Hospital (Full Name) :____
Street Address City/State/Zip ____
Type of Internship Specialty – YEAR ____
Please provide a copy of Post Graduate Training certificates and/or diploma for your file.

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 OR USMLE	DATE	SCORE
Step I		
Step II		
Step III		
PE/CS		

***Please provide a copy of your official transcript for your file.**

5. **LICENSING OF ANY TYPE:**

License (Name of State and County): ____

License Number: ____

License /Date Issued /Expiration Date: ______________________________________

***Please provide a copy of your Medical Licensure if it is still active.**

MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS & COLLEGES:

AOA Member #____________________ ACOI Member #________________________

AMA#_____________________________ ACP#______________________________

ACC#_________________________________ ASNC#____________________________

____

(Name, office held, if applicable and dates).

PHOTO: (Please attach a recent photograph of yourself)

BIRTH CERTIFICATE: Please provide an original and/or notarized copy of your Birth Certificate

CERTIFICATION: Please provide a copy of current ACLS/BLS/PALS

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 provide a copy of your immunization record.

*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**

<u>REFERENCES</u>: At least three (3) physician Letters of Recommendation.
Please provide complete mailing addresses, including postal zip codes and telephone numbers. (The hospital, at its option may contact references other than those chosen).
*Please provide 3 letters of recommendation.

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**

<u>DISCIPLINARY ACTIONS:</u>

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

<u>AUTHORIZATION:</u>

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

In making application for program acceptance, I agree to abide by the policies and procedures and 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 Graduate Medical Education Office, Board of Directors, Hospital Administration/Human Resources, 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, Graduate Medical Education Office, Hospital Administration/Human Resources, 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 immediate dismissal from the Residency Program at Magnolia Regional Health Center.

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

Signature of Applicant Date

AUTHORIZATION FOR RELEASE OF INFORMATION AND

RELEASE FROM CIVIL LIABILITY

I specifically authorize Magnolia Regional Health Center and its authorized representatives to consult with the management and members of the medical staffs of other hospitals, health care facilities, previous colleges/universities and/or other institutions with which I have been associated and with others who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter. This University or its authorized representatives may inquire and inspect all records and documents that may be material to the above.

I hereby release from civil liability any individual or institution reviewing or providing information relative to my application for fellowship at Magnolia Regional Health Center.

____ ________________
(Applicant's Signature) (Date)

____
(Print Name)

FOR GME OFFICIAL USE ONLY:

Appointment recommended: Y / N **Appointment deferred Y / N**

Comments: ____

____________________ ____________________________
Date Cardiology Fellowship Program Director

Comments: ____

____________________ ____________________________
Date Designated Institutional Official

Comments:

____

____________________ ____________________________
Date Office Graduate Medical Education

8.2.17 gl

PLEASE RETURN COMPLETED APPLICATION TO:

Office of Graduate Medical Education
Magnolia Regional Health Center
ATTN: Gena Lindsey
611 Alcorn Drive
Corinth, MS 38834