

**APPLICATION FOR**

**APPOINTMENT**

**TO THE**

**NORTON COMMUNITY HOSPITAL**

**RESIDENCY & INTERNSHIP**

**PROGRAMS**

## APPLICATION FOR INTERNSHIP/RESIDENCY

Please type or print legibly. Give complete information including street address and zip codes. Place a response in each blank. Use "N/A" or "NONE" where applicable.

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Last First Middle

Place of Birth \_\_\_\_\_

Office Address \_\_\_\_\_ Telephone \_\_\_\_\_

Residence Address \_\_\_\_\_ Telephone \_\_\_\_\_

Are you a U.S. citizen? \_\_\_\_\_ Alien Registration # \_\_\_\_\_ Expiration Date \_\_\_\_\_

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**PRE-MEDICAL EDUCATION:**

College or University \_\_\_\_\_

Street Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Degree/Date \_\_\_\_\_ Honors \_\_\_\_\_

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**MEDICAL EDUCATION:**

Medical School \_\_\_\_\_

Street Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Degree/Date \_\_\_\_\_ Honors \_\_\_\_\_

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**INTERNSHIP (For residency applicants only):**

Hospital (Full Name) \_\_\_\_\_

Street Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Type of Internship \_\_\_\_\_ Specialty \_\_\_\_\_

Practitioners Responsible for Performance (Chief of Staff, Chairmen of Departments, Others) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Facility (Full Name) \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Dates \_\_\_\_\_

Type \_\_\_\_\_

Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept., etc) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Facility (Full Name) \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Dates \_\_\_\_\_

Type \_\_\_\_\_

Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept., etc) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**MEDICAL EDUCATION POST -GRADUATE**

ON SEPARATE SHEET, LIST ALL POSTGRADUATE ACTIVITIES THAT YOU HAVE ATTENDED OR FOR WHICH YOU HAVE RECEIVED CREDIT IN THE PAST TWENTY-FOUR MONTHS.

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).

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*I have already passed the examinations checked below on the dates indicated:*

<u>COMLEX</u>	<u>DATE</u>	<u>SCORE</u>
NBOME, Part I	_____	_____
NBOME, Part II	_____	_____
NBOME, Part III	_____	_____

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**LICENSING OF ANY TYPE:**

License (Name of State and County) \_\_\_\_\_

License Number \_\_\_\_\_ Date Issued \_\_\_\_\_ Date Expires \_\_\_\_\_

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**MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS & COLLEGES:** (Name, offices held, if applicable and dates). Please notify the Medical Staff Office if you become a member after filing application.

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**LIST CONTINUING MEDICAL EDUCATION ACTIVITY DURING THE PAST FOUR (4) YEARS:**

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**HEALTH STATUS:** (please attach a copy of last health exam or letter from examining physician).

Present State of Health \_\_\_\_\_ Date of Last Health Exam \_\_\_\_\_

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

Name, address & telephone # of examining physician \_\_\_\_\_

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**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: \_\_\_\_\_

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**TYPE OF PROGRAM APPLIED FOR:**            ( )    House Staff-Training (Trad. Internship)  
    ( )    Internal Medicine  
    ( )    Family Practice

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

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

Have you ever been denied Professional Liability Insurance?  Yes  No

**DISCIPLINARY ACTIONS:**

HAVE ANY OF THE FOLLOWING EVER BEEN OR ARE ANY CURRENTLY IN THE PROCESS OF BEING DENIED, REVOKED, SUSPENDED, REDUCED, LIMITED, PLACED ON PROBATION, NOT RENEWED, OR VOLUNMTARILY 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 Norton Community Hospital).

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

**PHOTO:** (Please attach a recent photograph of yourself)

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**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.

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**FOR OFFICIAL USE ONLY:**

Appointment recommended \_\_\_\_\_ Appointment not recommended \_\_\_\_\_ Appointment deferred \_\_\_\_\_

Comments:

\_\_\_\_\_

\_\_\_\_\_  
Chairman, Graduate Medical Education Committee

Appointment recommended \_\_\_\_\_ Appointment not recommended \_\_\_\_\_ Appointment deferred \_\_\_\_\_

Comments:

\_\_\_\_\_

\_\_\_\_\_  
Director of Medical Staff

Appointment recommended \_\_\_\_\_ Appointment not recommended \_\_\_\_\_ Appointment deferred \_\_\_\_\_

Comments:

\_\_\_\_\_

\_\_\_\_\_  
Service Chair

Appointment recommended \_\_\_\_\_ Appointment not recommended \_\_\_\_\_ Appointment deferred \_\_\_\_\_

Comments:

\_\_\_\_\_

\_\_\_\_\_  
Executive Committee

Appointment recommended \_\_\_\_\_ Appointment not recommended \_\_\_\_\_ Appointment deferred \_\_\_\_\_

Comments:

\_\_\_\_\_

\_\_\_\_\_  
Secretary, Board of Trustees

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**RETURN COMPLETED APPLICATION TO:**

**KENNY BOYD  
NORTON COMMUNITY HOSPITAL, INC.  
100 15<sup>TH</sup> STREET, NW  
NORTON, VA 24273**

