**ADVENT HEALTH ORLANDO**

**NEURO CRITICAL CARE FELLOWSHIP APPLICATION**

**PERSONAL INFORMATION**

First Name:

Last Name:

Email:

Phone:

Street Address, City, State, Zip:

Date of Birth:

SSN:

**EDUCATION AND TRAINING**

**Please add additional degrees/training at the end**

College Attended, City/State/Country:

Bachelor Degree Earned, Year Graduated:

College Attended, City/State/Country:

Graduate Degree Earned, Year Graduated:

Medical School Attended, City/State/Country:

Year Graduated:

Internship Facility:

Internship Type:

Internship City/State/Country:

Month/Year started to Month/Year completed:

Residency Facility:

Residency Type:

Residency City/State/Country:

Month/Year started to Month/Year completed:

Fellowship Facility:

Fellowship Type:

Fellowship City/State/Country:

Month/Year started to Month/Year completed:

**PROFESSIONAL EXAMS**

USMLE/COMLEX I Year(s), Pass/Fail:

USMLE/COMLEX II Written Year(s), Pass/Fail:

USMLE/COMLEX II Practical Year(s), Pass/Fail:

USMLE/COMLEX III Year(s), Pass/Fail:

**For the next 3 questions, please write “N/A” if you have not taken any board certification exams**

Current Board Certification, Original certification year, and expiration:

Have you ever failed an examination for initial board certification?

If Yes, please list name of board and dates of any/all failed exams:

Have you ever had your certification status revoked or not renewed by any specialty board?

**PROFESSIONAL PRACTICE AND CONDUCT QUESTIONS**

1. Has your professional license or registration ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished, surrendered, or not renewed by any licensing board of any health-related agency or organization, or is there a review pending?

Yes  No

1. Has your DEA registration ever been revoked, suspended, limited, or conditioned in any way, or have you ever voluntarily relinquished your DEA registration, or is there a review pending?

Yes  No

1. Has your membership, participation, clinical privileges, or employment ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?

Yes  No

1. Have you ever voluntarily or involuntarily relinquished your membership, participation, clinic privileges, or request for privileges, employment, professional license, or registration as an alternative to disciplinary action, or prior to or during an investigation into your professional conduct or competence?

Yes  No

1. Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing board, peer review organization, third party payer, clinic, hospital, medical staff, any health-related agency or organization, or any educational institution?

Yes  No

1. Has your certificate or participation in any private, federal, (e.g. Medicare, Medicaid, etc.) or state health insurance program ever been restricted, denied, suspended, modified, terminated, revoked, or been relinquished voluntarily or involuntarily, or is any investigation or proceeding with respect to any such action presently underway?

Yes  No

1. Are there any charges currently pending against you or have you ever been convicted of a felony, misdemeanor or other offense (other than a minor traffic violation)?

Yes  No

1. Have you ever been named in a civil case? (e.g. tort claims, malpractice, personal injury, bankruptcy, defamation, etc) If yes, please provide details.

Yes  No

1. Have you ever had any professional liability claims or lawsuits brought against you, including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments? (If Yes, see back page for addendum to complete).

Yes  No

1. Has your professional liability carrier ever refused or canceled your coverage?

Yes  No

1. Have you ever been enrolled in a Professional Resource Network (PRN) or a similar state-sponsored resource network for items such as chemical dependency, psychiatric illness, neurological or cognitive impairment, and/or behavioral disorders.

Yes  No

1. If you are the citizen of another country, are there any visa issues or requirements that would prevent you from obtaining appropriate, lawful status of employment in the United States?

Yes  No  N/A, I am a US citizen

1. Have you ever been the subject of any reports to a state or federal databank (e.g. NPDB, FSMB)?

Yes  No

1. Do you need to purchase tail coverage from your current carrier? If no, please explain (e.g. you have occurrence-based coverage, completing training, etc). If you are a resident and have never done any moonlighting, select N/A.

Yes  No  N/A

1. Have you ever practiced without insurance or allowed a claims-made policy to lapse without the purchase of tail or nose coverage?

Yes  No

1. Do you or any family members have ownership interests in any organizations, companies, or commercial properties? (Family members include a husband or wife, birth or adoptive parent, child or sibling, father-in-law, mother-in-law, brother- in-law, sister-in-law, grandparent or grandchild.)

Yes  No

1. Do you have any outside activities that would involve professional services such as medical directorships at other organizations, board member at any non-Adventist Health System entity, expert case review, review of medical records or patient evaluations for law firms, provide professional services at another health care organization, consult or speak for pharmaceutical or medical device companies?

Yes  No

1. Do you own or have any ownership interest in medical office buildings in the Central Florida area?

Yes  No

**If you answered “Yes” to Questions 1-13 or 14-18, or if you answered “No” to question 14, please explain here.**