APPLICATION FOR COMMUNITY EDUCATOR FACULTY APPOINTMENT

The CMU College of Medicine Community Educator faculty appointment is for those individuals whose primary responsibility and source of income is outside CMU, but who agree to provide educational services in support of CMU's mission. Appointment length varies but is generally for three years and is renewable. Promotion is based on meeting established minimum criteria approved by the College of Medicine.

This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. If a particular field is not applicable to you, please indicate with "N/A".

Return all completed applications to:
Faculty & Staff Affairs | CMED South, 2520 S. University Park Drive, Bldg D., Mount Pleasant, MI 48859

Incomplete applications or missing information may delay appointment.

REGION AFFILIATION:

□ Great Lakes Bay Region □ Central Michigan □ Northern Michigan □ The Thumb □ West Michigan
□ Southeast Michigan □ Upper Peninsula □ Other_____

DISCIPLINE:

□ Medical Sciences □ Surgical Sciences

DEPARTMENT: I am requesting appointment in the department(s) of:

□ Emergency Medicine □ Pediatrics □ Radiology
□ Family Medicine □ Psychiatry □ Surgery
□ Internal Medicine □ Obstetrics & Gynecology □ Other_____

SECTION 1 – DEMOGRAPHICS

APPLICANT INFORMATION							
Last Name		First		M.I.		Degree(s)	
Other names used			Gender	□ Male □ Female			
Preferred Mailing Address □ Home □ Office							
Street Address				Apartment/Unit #			
City		State		ZIP			
Telephone Number		Cell Phone					
Business Phone		Email Address					
Birth Date		Social Security No.					
Citizenship	□ U.S. Citizen □ Non Resident Alien □ Non-Citizen Nat'l of U.S. □ Permanent Resident						
Type of Visa		Country of Citizenship					
Ethnicity/Race	□ Of Hispanic or Latino Origin □ Not of Hispanic or Latino Origin						
Please check at least one status as well as all that apply	□ American Indian or Alaskan Native □ Asian						

	□ Black or African American	□ Hawaiian/Pacific Islander	□ White

OFFICE INFORMATION

Present Employer:		Department Name	
Primary Office Street Address			
City		State	ZIP
Office Manager		Telephone Number	Fax Number

SECTION 2 – EDUCATION/CLINICAL TRAINING

UNDERGRADUATE EDUCATION

College or University Name			
Address (street, city, state, zip code)			
Degree Received		Graduation Date (MM/YYYY)	

MEDICAL/PROFESSIONAL EDUCATION

College or University Name				Degree Received			
Address (street, city, state, zip code)							
From (MM/YYYY)		To (MM/YYYY)		Did you graduate?	YES ☐	NO ☐	Graduation Date

OTHER POSTGRADUATE EDUCATION (Attach additional sheet if necessary) ☐ **Does not apply**

Institution		Dates Attended	
Address (street, city, state, zip code)			

INTERNSHIP (Attach additional sheet if necessary) ☐ **Does not apply**

Institution			Program Specialty			
Address (street, city, state, zip code)						
From (MM/YYYY)		To (MM/YYYY)		Did you complete?	YES ☐	NO ☐

RESIDENCIES (Attach additional sheet if necessary) ☐ **Does not apply**

Institution			Program Specialty			
Address (street, city, state, zip code)						
From (MM/YYYY)		To (MM/YYYY)		Did you complete? (if NO, please explain on separate sheet)	YES ☐	NO ☐
Institution			Program Specialty			
Address (street, city, state, zip code)						
From (MM/YYYY)		To (MM/YYYY)		Did you complete? (if NO, please explain on separate sheet)	YES ☐	NO ☐

FELLOWSHIPS (Attach additional sheet if necessary) ☐ **Does not apply**

Institution		Program Specialty	
Address (street, city, state, zip code)			

From (MM/YYYY)		To (MM/YYYY)		Did you complete? (if NO, please explain on separate sheet)	YES ☐	NO ☐
Institution				Program Specialty		
Address (street, city, state, zip code)						
From (MM/YYYY)		To (MM/YYYY)		Did you complete? (if NO, please explain on separate sheet)	YES ☐	NO ☐

SECTION 3 – LICENSURE/REGISTRATIONS & CERTIFICATIONS

LICENSURE				**Does not apply**
Physicians at CMU College of Medicine are responsible for obtaining the appropriate licensures to practice medicine in the State of Medicine and are also responsible for maintaining active and current licensure for patient care. Licensed status must be maintained for the duration of your appointment.				
Michigan State Medical/Professional License No.		Issue Date (MM//DD/YYYY)	Expiration Date (MM/DD/YYYY)	
Michigan State Controlled Substance No.			Expiration Date (MM/DD/YYYY)	
Drug Enforcement (DEA) Administration Certification No.			Expiration Date (MM/DD/YYYY)	
ALL OTHER STATE MEDICAL/PROFESSIONAL LICENSES				
State _____	License No. _____		Expiration Date (MM/YYYY)	
State _____	License No. _____		Expiration Date (MM/YYYY)	
ECFMG No. _____ ☐ or NA				

SECTION 4 – AFFILIATIONS

PRIVILEGES					☐ **Does not apply**
Hospital					
Address (street, city, state, zip code)					
Hospital					
Address (street, city, state, zip code)					
PREVIOUS ACADEMIC EXPERIENCE					☐ **Does not apply**
Institution					
Address (street, city, state, zip code)					
From (MM/YYYY)		To (MM/YYYY)		Position	
Institution					
Address (street, city, state, zip code)					
From (MM/YYYY)		To (MM/YYYY)		Position	

SECTION 5 – ATTESTATION QUESTIONS

Please answer the questions "yes" or "no". **If your answer to any of the questions 2-17 is "yes", please provide full details and reasons on a separate sheet.**

An affirmative answer to any of these questions does not automatically disqualify you from an appointment at the CMU College of Medicine but may result in further follow-up or investigation for credentialing purposes.

NOTE: All information is for credentialing purposes only. Information will remain confidential.

1)	Are you currently able, with or without reasonable accommodation, to perform delineated clinical activities and other Resident Physician duties?	☐ YES ☐ NO
2)	Do you have or have you ever had any license revoked, suspended, denied, restricted, limited or issued/placed in a probationary status or voluntarily relinquished?	☐ YES ☐ NO
3)	Have you ever had a DEA Certificate revoked, suspended, limited, restricted in any way or voluntarily relinquished?	☐ YES ☐ NO
4)	Have you ever voluntarily not renewed your DEA license, Medical or Dentistry License in any state?	☐ YES ☐ NO
5)	Have you ever been terminated, placed on probation or otherwise disciplined from a residency program or medical staff?	☐ YES ☐ NO
6)	Have your privileges at any hospital ever been refused, suspended, diminished, revoked or not renewed?	☐ YES ☐ NO
7)	Have you ever voluntarily withdrawn your privileges or resigned from any hospital or training program?	☐ YES ☐ NO
8)	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization?	☐ YES ☐ NO
9)	Have you ever been named in a malpractice case?	☐ YES ☐ NO
10)	Are you now, or have you ever been, involved in Administrative, professional, or judicial proceedings in which malpractice on your part is or was alleged? If "yes", please complete the enclosed SUPPLEMENTAL CLAIMS INFORMATION FORM for each claim.	☐ YES ☐ NO
11)	Have you ever been subject to disciplinary action for academic or other reason in any of the colleges, universities, graduate or professional schools you have attended?	☐ YES ☐ NO
12)	Have you ever been convicted of a crime other than minor traffic violations?	☐ YES ☐ NO
13)	Have you ever been convicted of a felony?	☐ YES ☐ NO
14)	Are you aware of any criminal charges pending or expected to be brought against you?	☐ YES ☐ NO
15)	Do you have any contagious or communicable diseases that could endanger others?	☐ YES ☐ NO
16)	Have you ever been addicted to or dependent upon intoxicating liquor, narcotics or other illegal drug substances?	☐ YES ☐ NO
	a) Has this addiction ever permanently, presently or chronically impaired or distorted your judgment, behavior, or capacity to recognize reality or ability to cope with the ordinary demands of life?	☐ YES ☐ NO
17)	Are you delinquent on any Federal debt? (Include delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults on any Federally guaranteed or insured loans such as student or home mortgage loans).	☐ YES ☐ NO

Please indicate the area(s) of academic service you are most interested in providing:

- □ Teaching/precepting preclinical students (PBL, Clinical Skills, Ethics, guest lectures, etc.)
- □ Teaching/precepting clinical students in my office or the hospital
- □ Serving on a College of Medicine committee (Admissions, Curriculum Development, etc)
- □ Acting as a formal mentor for students
- □ Teaching residents in a College of Medicine sponsored or affiliated residency program
- □ Engaging with students or residents on a research project
- □ Other_____

PLEASE INCLUDE A CURRENT CURRICULUM VITAE WITH THIS APPLICAITON

To the best of my knowledge, I certify that all information provided in this application is correct.

Signature:_____ **Date:** _____

SECTION 6 – ATTESTATION, AUTHORIZATION AND RELEASE AND ACKNOWLEDGEMENT OF TRAINING AND EDUCATION RESPONSIBILITY

CONSENT AND RELEASE

In applying for appointment at the CMU College of Medicine, I certify that the statements in this application are true and complete and I understand and agree that misstatements or omissions in this application may be grounds for summary dismissal from appointment. I agree to immediately report any changes in the status of my medical license or any changes in my status at other hospitals, to Faculty and Staff Affairs.

I will be responsible for the medical care of the patient, for prompt and accurate completeness of medical records, for transmitting reports of the patient's condition to concerned parties who are entitled to such information, and for providing or appropriately arranging for continuity of care.

I agree to report any changes in my health status that could adversely affect my ability to practice medicine and agree, with reasonable cause, to submit to a physical examination, drug and alcohol screens and other assessments acceptable to Faculty and Staff Affairs, should this be considered necessary.

If I am ever under investigation by any regulatory agency (e.g., the State of Michigan Department of Consumer and Industry Services), I am responsible for immediately informing Faculty and Staff Affairs of the agency involved, the basis for the complaint and the final resolution or outcome.

I recognize ***it is my responsibility, and mine alone***, to maintain appropriate licensure at all times. I agree to abide by all rules and regulations regarding same and I realize it is unlawful to practice medicine without an active license.

I hereby authorize agents of the University to consult with other universities, hospitals and members of their medical staffs, and with licensing boards, and with anyone who may have information bearing on my competence, my character or my ethical qualification. I further authorize agents of the University to make inquiries from the said individual hospitals, boards, and courts concerning any claims, lawsuits, disciplinary actions, license restrictions or denials, or any other matters affecting my ability to practice my profession. I hereby consent to the release from any source, including information that would otherwise be privileged or confidential, to the CMU College of Medicine, of any and all information concerning my conduct and abilities to practice.

I hereby authorize and release from liability, the CMU College of Medicine and all managed care organizations or other third party payers, insofar as the University provides information from my credentialing file, including information that is confidential and/or privileged, or permits access to my file to such other organizations or payers with a need to independently evaluate or verify my credentials, or audit CMU College of Medicine's credentialing process and decisions.

I hereby release from liability all individuals and organizations that provide information concerning my qualifications for appointment. I further release from liability the CMU College of Medicine, its staff, officers and employees who make inquiries concerning my conduct and abilities to practice, and I hereby indemnify them from any claim arising from their consideration, award or denial of my application.

I certify that the information submitted on this application is complete and correct to the best of my knowledge. I understand that any false, misleading or missing information may be cause for withdrawal of the preliminary appointment.

Signature _____ Date: _____

Printed Name _____