Application For Employment
Clinical Academic Faculty

INSTRUCTIONS: Please complete the information requested information in ink. Fill in all areas as accurately and completely as possible. If you are mailing the application, please return the application and all associated documents to:
Morehouse School of Medicine
Human Resources Department
720 Westview Drive, SW
Atlanta, Georgia 30310-1495

_____
Date of Application

Name: _____ _____ _____ **Social Security #** _____
Last **First** **Middle**

Present Address: _____ _____ _____ _____
Number and Street **City** **State** **Zip Code**

Telephone: _____ _____ _____ _____
Home **Business** **Other** **Email**

Position(s) applying for: _____ in _____
Subject Area **Department**

With the rank of ◯ **Professor** ◯ **Associate Professor** ◯ **Assistant Professor** ◯ **Instructor**

How did you hear about this position? _____

Would you accept: ◯ **Full-time** ◯ **Part-time** ◯ **Either** **If Part-time, what hours?** _____

Are you legally authorized to work in the United States? ◯ **Yes** ◯ **No**

Will you now or in the future require sponsorship for employment visa status (e.g., H1-B visa status) ◯ **Yes** ◯ **No**

Have you been previously employed by the School of Medicine? ◯ **Yes** ◯ **No** **If yes, when?** _____

What was your reason for leaving? _____

If your application is considered favorably, on what date will you be available for work? _____

Have you ever been convicted of a crime or sentenced to prison? (Felony Convictions Only) ◯ **Yes** ◯ **No**

If yes, describe in detail providing dates and disposition:

_____

_____

EDUCATION AND SKILLS

High School _____ **City & State** _____

Year Graduated or Highest Grade Completed _____

Colleges and Universities Attended	City and State	Years Attended		Major and Minor Subjects	Degree and Year Granted
		From	To		
Undergraduate Education					
Graduate Education					
Residency/Postgraduate Training					

List any other courses, studies of training leading to certificate, diploma, or degree:

LICENSES/CERTIFICATIONS/SPECIALTIES

List all current and past licenses:

State	License No.	Date Issued		Expiration Date	Status

If the answer to any of the following questions is YES, please provide details on a separate sheet.

1. Have proceedings ever been instituted to have your license to practice medicine limited, suspended, revoked, denied, or subject to probationary conditions? ◯ Yes ◯ No
2. Have proceedings ever been instituted to have your DEA license or other controlled substance authorization denied, revoked, or suspended? ◯ Yes ◯ No
3. Have proceedings ever been instituted to have your specialty board certification denied, revoked or suspended? ◯ Yes ◯ No
4. Have you ever been a defendant in a criminal proceeding related to the practice of medicine? ◯ Yes ◯ No

Licensure Exam:

National Board No.:
USMLE No.:
Flex No.:
State Board No.:
If foreign medical graduate, ECFMG No.:

(If a Foreign Medical Graduate, ECFMG certificate is to be submitted to the department)

Have you ever been convicted of a crime or sentenced to prison? (Felony Convictions Only) ◯ **Yes** ◯ **No**

If yes, describe in full, including the final disposition and date(s):

Federal DEA Registration No. _____ Dated Issued: _____ Expiration Date: _____

SPECIALTY BOARD CERTIFICATION (S)

Specialty	Certification Date	Expiration Date	Re-Certification Date

If not certified, state your intent with respect to becoming certified and describe the status of your efforts and eligibility, including pas efforts and failures of written or oral exams, if any:

Please provide all hospital affiliations, employers and locum tenens.

FORMAL CLINICAL TEACHING EXPERIENCE

Name and Location of School	Rank and/or Title	Teaching Field	Years		Salary
			From	To	

EXPERIENCE OTHER THAN TEACHING

Position	Employer	Address	Years	Salary

CURRENT CLINICAL PRIVILEGES

Name of Institution	Location (address)	Appointment

REQUEST FOR MSM STAFF CATEGORY AND STAFF PRIVILEGES

The Applicant requests that privileges be delineated in the following field(s):

1. _____
2. _____

The Applicant desires the following specific clinical privilege(s):

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

List equipment on which you have been trained to perform special medical procedures.

Equipment	Date Certified	No. of Procedures

CHRONOLOGICAL PREOFESSIONAL HISTORY

If the answer to any of the following questions is YES, please provide full details on a separate sheet.

A. Have your clinical privileges at any hospital or healthcare institution been limited, suspended, revoked, not renewed, or subject to probationary conditions, or have proceedings toward any of those ends been instituted or recommended by a medical staff official or committee or governing board? ◯ Yes ◯ No

B. Have your medical staff membership of medical staff status at any hospital or healthcare institution been limited, suspended, revoked, not renewed, or subject to probationary conditions, or have proceedings toward any of those ends been instituted or recommended by a medical staff official or committee or governing board? ◯ Yes ◯ No

C. Have you been denied membership on any hospital medical staff, or advancement in medical staff status, or has such a denial been recommended by a medical staff official or committee or governing board? ◯ Yes ◯ No

D. Has your request for any specific clinical privilege(s) been denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship) or has such a denial or limitation been recommended by a medical staff official or committee or governing board? ◯ Yes ◯ No

E. Have you voluntarily relinquished any medical staff membership, or clinical privilege(s) while under investigation or disciplinary action? ◯ Yes ◯ No

PROFESSIONAL LIABILITY HISTORY

If the answer to any of the following questions is YES, please provide full details on a separate sheet.

1. Have you ever practiced medicine without liability coverage? ◯ Yes ◯ No
2. Have you ever been denied professional liability insurance or has your policy ever been cancelled or denied renewal? ◯ Yes ◯ No

3. Have you ever been a defendant in a malpractice/professional liability suit, or have you ever received written notice of intent to file such a suit? ◯ Yes ◯ No

List **ALL** insurance carriers (including insurance companies, hospitals, clinics, employers, etc.) who have provided professional liability coverage.

Current Insurance Carrier:			**From**	**To**
Address			**Policy Number**	
City	**State**	**Zip Code**	**Years with Company**	

Insurance Carrier:			**From**	**To**
Address			**Policy Number**	
City	**State**	**Zip Code**	**Years with Company**	

Insurance Carrier:			**From**	**To**
Address			**Policy Number**	
City	**State**	**Zip Code**	**Years with Company**	

Insurance Carrier:			**From**	**To**
Address			**Policy Number**	
City	**State**	**Zip Code**	**Years with Company**	

PROFESSIONAL REFERENCES

List individuals other than those listed elsewhere in this application who have observed your clinical performance during a recent period.

Name			**Professional Relationship**
Address			**Length of Relationship**
City	**State**	**Zip Code**	**Phone Number**

Name			**Professional Relationship**
Address			**Length of Relationship**
City	**State**	**Zip Code**	**Phone Number**

Name			**Professional Relationship**
Address			**Length of Relationship**
City	**State**	**Zip Code**	**Phone Number**

Name	**Professional Relationship**
Address	**Length of Relationship**

City	State	Zip Code	Phone Number

CONTINUING MEDICAL EDUCATION

Please provide primary continuing medical education credits for the past two years

Course Title/Location	Dates	CME Credit Hours

ADVANCED LIFE SUPPORT CERTIFICATION:

Course Sponsor				Expiration Date
Address	City	State	Zip Code	Phone

PROFESSIONAL MEMBERSHIPS & ORGANIZATIONS

Organization/Location	Dates
1.	
2.	
3.	
4.	
5.	

CERTIFICATION

I understand that any misrepresentations, false statements, false information, or material omissions made by me on this Application for Employment (or on any accompanying or required related documents) and/or during any interview may result in the exclusion of my application from further consideration or if I am hired, termination of my employment, regardless of when or how discovered.

In making this application for appointment to the Faculty and membership in Morehouse Medical Associates, Inc. (MMA), I .agree to abide by the by-laws, rules, and regulations of the Faculty, and MMA, and I further agree to abide by such rules and regulations as may be from time to time enacted. I am familiar with the principles and standards of the Joint Commission on Accreditation of Health Care Organizations and the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty and/or profession, and I agree to be bound by the terms thereof if I am granted membership or clinical privileges, and I further agree to be bound by the terms without regard to whether or not I am granted membership of clinical privileges in all matters relating to the consideration of my application for appointment to the Faculty and to MMA.

By applying for appointment to the Faculty and membership in MMA, I hereby signify my willingness to appear for the interviews in regard to my application, authorize the school, its professional staff and their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the school, its professional staff and its representatives of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my moral and ethical qualifications for membership. I hereby release from liability, all representatives of the school and its professional staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the school, it professional staff, in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

☐ **I certify that all information provided is true and complete.**

Applicant's Signature _____ Date _____

Human Resources Department

RELEASE OF INFORMATION
(Supplemental to Employment Application)

AN EQUAL OPPORTUNITY EMPLOYER

I hereby give consent and authorization to the Morehouse School of Medicine and/or its designee to obtain any information which is relevant to my application for employment. Any person(s) or organization(s) directed to furnish such information upon request.

The release of information is given with any full knowledge and understanding. With my signature below, I release any person(s) or organization(s) and their employees, agents and officials acting in an official capacity, form liability for complying with this release.

_____ _____

Applicant's Signature Date

MOREHOUSE SCHOOL OF MEDICINE

Affirmative Action Self ID Survey

Applicants and employees are treated without regard to race, color, religion, sexual orientation, gender, national origin, citizenship status (unless required by a government contract), age, marital or veteran status, physical or mental disability, or any other legally protected status during every aspect of the employment process.

As employers and government contractors, we comply with government regulations and affirmative action responsibilities. Solely to help us comply with affirmative action record keeping, reporting and other legal requirements, please complete the survey below. This information will not be used for hiring, placement, or other decisions related to the terms and conditions of employment. This document will be kept in a confidential file, separate from applicant and personnel files. When reported, data will not identify any specific individual.

YOUR COOPERATION IS VOLUNTARY
INCLUSION OR EXCLUSION OF ANY DATA WILL NOT AFFECT ANY EMPLOYMENT DECISION

Please complete the following information. *Please print.*

Last Name:	First Name:
Date:	Job Title/Req Number:

Gender

☐ Male ☐ Female

Ethnicity - Are you Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

☐ Yes ☐ No

Race - If you are not Hispanic or Latino, please select the appropriate race category.

☐ White (Not Hispanic or Latino) - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ Black or African American (Not Hispanic or Latino) – A person having origins in any of the Black racial groups of Africa.

☐ Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino) - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ Asian (Not Hispanic or Latino) - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ American Indian or Alaska Native (Not Hispanic or Latino) - A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

☐ Two or More Races (Not Hispanic or Latino) - persons who identify with more than one of the above five races.

☐ I respectfully decline completing the information being requested above. _____ *initials*

Disclosure and Written Authorization To Obtain a Consumer Report or Investigative Consumer Report

By this document, Morehouse School of Medicine and Vericon Resources, Inc. disclose to you that they may obtain a consumer report and/or an investigative consumer report for employment purposes as part of a pre-employment background investigation and/or at any time during your employment. "Consumer Reports" may include credit; driving; education; criminal records and other reports from consumer reporting agencies. An "investigative consumer report" is a consumer report in which information as to character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with neighbors, friends, associates, acquaintances, or others. You have a right to request disclosure of the nature and scope of an investigation and to request a written summary of consumer rights. You will be given a reasonable time in which to dispute any information found in the report if you so choose. See www.consumerfinance.gov/learnmore.

My signature below expressly authorizes Morehouse School of Medicine and any of its related companies and/or Vericon Resources, Inc. and/or any of their authorized agents to obtain consumer reports and/or investigative consumer reports regarding me for employment purposes as part of the pre-employment background investigation and/or at any time during my employment.

Signed: _____ Date: _____

The following is my true and complete legal name, and all information about it and my background is true and correct to the best of my knowledge. I understand that all inquiries on this form are used for identification purposes only in order to conduct a background check that is being conducted for legitimate business reasons, specifically for employment and/or continued employment purposes.

* Responses to sex, age, and race inquiries are voluntary, and choosing not to respond will not preclude hire or promotion.

Last Name, First Name, Middle Name (PLEASE PRINT LEGIBLY)	**Position Applying For**
Applicant's Signature and Date (required) _____ **Date:**_____	**Driver's License Number & State** **Lic #**_____ **State** _____

***Responses to the * questions are optional and voluntary, for Identification only.**

Social Security Number	***Date of Birth**	***Race**	***Sex** ☐ **M** ☐ **F**
Former Names and Time Frames			

Current Address	**City/State/Zip**	**County**	**Dates (Mo/Yr–Mo/Yr)**
Previous Addresses (Past 7 Years)			

If you would like a free copy of the consumer report prepared for you, please call 800-795-3784 and ask for extension 210. If you are applying for employment in the state of California, Minnesota or Oklahoma, would you like a copy of the consumer report prepared for you? (CA Civil Code Section 1786.22) _____ Yes _____No

If you are applying for employment or employed in New York, you will be receiving a copy of Article 23-A via your e-mail, along with a Notice that provides direction should you wish to inquire whether an investigative consumer report was requested. The notice contains the name and address of the appropriate consumer reporting agency.

FOR MOREHOUSE SCHOOL OF MEDICINE OFFICE USE ONLY:

Please complete the following section:

Please Check Services Requested:

☐**Addr Hist w/SSN** ☐ **7 yr comp crim** ☐**Sex Offender** ☐**Fed crim** ☐**Nat'l dbase** ☐**Credit** ☐**MVR** ☐**Drug** ☐**Ed** ☐**Emp**

Other (please list) _____

Contact Name and Phone #	**Cost Code (optional):**	**Date**

Phone: 800/795-3784
Fax: 800/915-1020

VERICON