

**YALE-NEW HAVEN HOSPITAL**  
*Recommendation for Appointment to the Clinical Fellow Staff*

**APPLICANT -- PLEASE COMPLETE THE FOLLOWING:**

<b>NAME</b>	<b>REQUESTED START DATE</b>
_____	_____
<b>SOCIAL SECURITY #</b>	
_____	
<b>DATE OF BIRTH</b>	<b>PLACE OF BIRTH</b>
_____	_____
<b>DEPARTMENT</b>	<b>SECTION</b>
_____	_____
<b>MEDICAL SCHOOL</b>	<b>YEAR GRADUATED</b>
_____	_____

POSTGRAD. YEAR: \_\_\_\_\_ for year beginning \_\_\_\_ (mo/yr), (# years in clinical training since graduation from medical school)

**Fellows Are Not Required To Have A Connecticut Medical License To Practice Within Their Fellowship Program, But To Practice Outside This Training Program, i.e., Moonlighting In The Emergency Room, A Connecticut License Is Required. If You Have A Connecticut License Please Enclose a Copy.**

**DEPARTMENT -- PLEASE COMPLETE THE FOLLOWING:**

**FUNDING SOURCE** \_\_\_\_\_ **EMPLOYER** \_\_\_\_\_

**HOSPITAL ADDRESS (Bldg. & Room #)** \_\_\_\_\_

**HOSPITAL TELEPHONE #:** \_\_\_\_\_

**HOSPITAL FAX #:** \_\_\_\_\_

**IS THIS PROGRAM ACGME APPROVED?** \_\_\_\_\_ YES \_\_\_\_\_ NO

**THIS APPLICANT IS A: (Check All Applicable)**

\_\_\_\_ Graduate from a school approved by the Council on Medical Education and Hospitals of the American Medical Association or by the American Dental Association

\_\_\_\_ Foreign medical school graduate who has passed an appropriate qualifying examination.

**ENCLOSE A COPY OF ECFMG CERTIFICATE.**

1. Agency giving examination \_\_\_\_\_

2. Date of successful completion of examination \_\_\_\_\_

3. Certificate Number \_\_\_\_\_

\_\_\_\_ Postdoctoral Fellow

**MALPRACTICE INSURANCE (check one):**

\_\_\_\_ University

\_\_\_\_ Hospital

\_\_\_\_ Other (send copy of Certificate of Insurance to Medical Staff Office).

\_\_\_\_\_  
**Signature of Chief of Department (Not Section Chief)**



2. To whom may your home phone number be released?

- No One
- Communications only (Page)
- Other Physicians only
- Health Care Professionals
- Anyone

3. Mobile Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

4. Yale Email/Internet: \_\_\_\_\_

Fax #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

5. Beeper: \_\_\_\_\_

YNHH Beeper: \_\_\_\_\_

VA Beeper: \_\_\_\_\_

Outside Beeper: \_\_\_\_\_

Instruction on  
Use of Beeper: \_\_\_\_\_

**D. MEDICAL LICENSURE/PRACTICE HISTORY INFORMATION**

**If you answer "yes" to any of the following questions, you must supply full details on a separate sheet.**

1. Connecticut State License Number: \_\_\_\_\_

**(Enclose Copy)**

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

2. Regarding your license to practice your profession in any jurisdiction:

- a. Has your application ever been denied?  Yes  No
- b. Has your license ever been limited, suspended or revoked?  Yes  No
- c. Has the relevant licensing board ever censured you for matters having to do with professional practice?  Yes  No
- d. Have you entered into a consent order, practice agreement, reinstatement order (or equivalent thereof) with any licensing board?  Yes  No
- e. Have you ever been fined by any licensing board?  Yes  No

3. Have you ever been, or are you currently, under investigation or involved in any proceeding involving your practice before any state licensing board?  Yes  No

4. Controlled Substance Status:

I am legally allowed to dispense narcotics and have a valid and current DEA number:

Yes

No

Federal DEA Number: \_\_\_\_\_ (enclose copy)

Connecticut DEA: \_\_\_\_\_ (enclose copy)

YNHH DEA: \_\_\_\_\_ (enclose copy)

5. Have you ever been denied a state or federal certificate of authority to prescribe controlled substances or is your state or federal certificate of authority to prescribe controlled substances currently under investigation?  Yes  No
6. Has your state or federal authority to prescribe controlled substances ever been voluntarily or involuntarily...  
a. limited by the agency?  Yes  No  
b. suspended?  Yes  No  
c. revoked?  Yes  No  
d. denied renewal?  Yes  No
7. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action by any medical organization?  Yes  No
8. Have you ever been sanctioned by a specialty board or has your specialty or sub-specialty certification ever been suspended or revoked?  Yes  No
9. Has your eligibility to participate in the Medicare or Medicaid program ever been suspended or terminate in any state or have you ever been threatened with exclusion or debarment from either program?  Yes  No
10. Have you ever been listed by the OIG (Office of Inspector General) as debarred, excluded or otherwise ineligible for Federal health program participation or otherwise sanctioned by the Federal government, including being listed on the EPLS (Excluded Parties List System)?  Yes  No
11. Have you ever been charged by any local, state, or federal authority, official or agency, plead guilty to or been convicted of any of the following :
- a. crimes or offenses related to the delivery of service under Medicare/Medicaid?  Yes  No
- b. crimes or offenses related to the abuse or neglect of patients in connection with the delivery of health care?  Yes  No
- c. crimes or offenses involving, fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of health care or involving any act or omission in a program financed in whole or in part by any federal, state or local government?  Yes  No
- d. obstruction of justice?  Yes  No
- e. crimes or offenses related to the manufacture, distribution, prescription or dispensing of any controlled substance?  Yes  No
- f. other crimes or offenses (including motor vehicle charges other than parking tickets)?  Yes  No
12. Have you ever been assessed a civil penalty by anyone for false or fraudulent submittal of claims for payment, or other violation of billing practice standards?  Yes  No
13. Have you ever been denied privileges or medical staff membership at any hospital or other health care facility?  Yes  No
14. Have you ever been the subject of disciplinary action and/or a hearing under any set of medical staff bylaws?  Yes  No

15. Have your hospital or other health care facility privileges or medical staff membership ever been voluntarily or involuntarily cancelled, challenged, reduced, surrendered, limited, suspended, not renewed, revoked or withdrawn?  Yes  No
16. Are you dependent upon any controlled substance or alcohol?  Yes  No
17. Are you currently engaged illegal drug use?  Yes  No
18. Do you have any physical, mental or emotional condition that would compromise your ability to practice medicine with reasonable skill and safety?  Yes  No
19. Have formal allegations ever been made against you related to any form of impairment, disruptive behavior or unprofessional conduct or have you ever been asked to seek an evaluation or counseling for such behavior?  Yes  No
20. Have you ever been reported to the National Practitioner Databank by any individual or organization for any reason?  Yes  No
21. Has any malpractice or professional liability claim been brought against you within the past ten (10) years?  Yes  No
- If yes, please describe on a separate sheet of paper.
22. Have you ever been denied professional liability coverage?  Yes  No

**E. BOARD CERTIFICATIONS**

Specialty Board	Issue Date/Term Date
_____	____/____
_____	____/____
_____	____/____
_____	____/____

**F. HOSPITAL PRACTICE**

1. Please provide proof of Advance Cardiac Life Support/Basic Life Support certification if you have it. (Not Required)
2. Article V. Section B1. of the Yale-New Haven Hospital Bylaws and the JCAHO mandate that you attest to any health condition that could affect your professional competence. You are also required to report any infectious disease or other conditions which could represent a risk to patients. Do you have any such condition?  
 \_\_\_ No  
 \_\_\_ Yes (please specify)

**G. MEDICAL SCHOOL AFFILIATION**

1. Indicate your primary appointment at YSOM:

- |  |  |
|--|--|
| <input type="checkbox"/> No Appointment                | <input type="checkbox"/> Postdoctoral Associate  |
| <input type="checkbox"/> Postdoctoral Fellow           | <input type="checkbox"/> Clinical Instructor     |
| <input type="checkbox"/> Lecturer                      | <input type="checkbox"/> Assist. Clin. Professor |
| <input type="checkbox"/> Research Scientist, Senior    | <input type="checkbox"/> Assoc. Clin. Professor  |
| <input type="checkbox"/> Research Scientist, Associate | <input type="checkbox"/> Clinical Professor      |
| <input type="checkbox"/> Research Scientist, Assistant |  |
| <input type="checkbox"/> Instructor                    |  |
| <input type="checkbox"/> Assistant Professor           |  |
| <input type="checkbox"/> Associate Professor           |  |
| <input type="checkbox"/> Professor                     |  |
| <input type="checkbox"/> Other (specify)               |  |

2. Primary Yale Medical School Department Affiliation:

- |   |   |
|---|---|
| <input type="checkbox"/> Anesthesiology             | <input type="checkbox"/> Neurology              |
| <input type="checkbox"/> Cell Biology               | <input type="checkbox"/> Obs/Gyn                |
| <input type="checkbox"/> Child Study Center         | <input type="checkbox"/> Ophthal./Vis.Serv.     |
| <input type="checkbox"/> Comparative Med.           | <input type="checkbox"/> Ortho/Rehab.           |
| <input type="checkbox"/> Dermatology                | <input type="checkbox"/> Pathology              |
| <input type="checkbox"/> Diagnostic Radiol.         | <input type="checkbox"/> Pediatrics             |
| <input type="checkbox"/> Epidem/Publ.Hlth.          | <input type="checkbox"/> Pharmacology           |
| <input type="checkbox"/> Human Genetics             | <input type="checkbox"/> Psychiatry             |
| <input type="checkbox"/> Intern. Med.               | <input type="checkbox"/> Psychology             |
| <input type="checkbox"/> Lab. Med.                  | <input type="checkbox"/> Surgery                |
| <input type="checkbox"/> Molec.Biophy.&<br>Biochem. | <input type="checkbox"/> Therapeutic .Radiology |

Other:

- Yale Nursing School

3. Other Affiliations with Yale University:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that I cannot submit a bill to Medicare or other payor for services rendered within the scope of my clinical fellow (postdoctoral) training.

I certify that the information provided above is true and complete.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_