Mount Sinai

GRADUATE MEDICAL EDUCATION TRAINEE APPLICATION

(INTERN/RESIDENT/FELLOW/ROTATOR)

BASIC INFORMATION

First Name	Middle Name	Last Name	Other/Former/Maiden Name(s)

Street Address	Apt #	City	State	Country	Zip Code

Home Phone Number	Mobile Phone Number	Email Address

Emergency Contact Name	Relationship to Applicant	Emergency Contact Phone Number

United States Military Service
Branch From To

Do you have any relatives who work in the Mount Sinai Health System?
☐ Yes; Name(s): ☐ No

National Provider Identifier (NPI)*	NYS Health Commerce System ID*	Drug Enforcement Administration (DEA) ID	Do you have a legal right to work in the United States? ☐ Yes ☐ No

* All house staff must have a National Provider Identifier Number and an active New York State Health Commerce System ("HCS") Account. If you do not have one or both, please contact your program coordinator for instructions.

TRAINING POSITION

Proposed Training Program (Specialty)	Proposed Postgraduate (PGY) Level

Proposed Start Date / /

Hospital (check one) ☐ Beth Israel ☐ Mount Sinai ☐ New York Eye & Ear ☐ St. Luke's-Roosevelt

EDUCATION HISTORY

(including undergraduate study and medical school; continue on a separate page if needed)

Institution Name/Location	Dates Attended	Degree, Honors, Awards
	to	
	to	
	to	

PREVIOUS HOSPITAL EXPERIENCE

(including any previous GME training and medical staff appointments; continue on a separate page if needed)

Institution Name/Location/Department	Dates Appointed	Title
	to	
	to	
	to	

MEDICAL LICENSURE

State	License e	Expiration Date

BOARD CERTIFICATION

Specialty	Certifying Organization	Year of Certification	Renewal Year

The hospitals of the Mount Sinai Health System select trainees based on their ability and without regard to race, color, creed, religion, national origin, age, gender, marital status, military status, disability, citizenship, genetic predisposition, sexual preference, or any other characteristic protected by law.

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CONFIDENTIAL PROFESSIONAL INFORMATION

You have an obligation to disclose all information that may be in any way relevant to an evaluation of your application. Failure to fully disclose any potentially relevant information whether or not specifically called for in this Section, may lead to denial or loss of graduate medical education appointment. The following table is designed to assist you in determining what information is required to ensure a complete disclosure.

I. Entities	II. Actions
• Government Agency including: Federal, State, Local, DEA, Office of Professional Medical Conduct, Department of Education, Department of Health • Hospital or other health care facility • Practice Group including: PC, LLC, Partnership • Residency Review Committee • American Medical Association or other Professional Organization • Payers including: Managed Care Plans, Medicare, Medicaid • Specialty Boards	• Censure • Termination • Suspension (regardless of whether it was stayed) • Reduction or Restriction of Privileges or Coverage (voluntary or involuntary) • Probation • Warning • Denial of Licensure, Certification or Completion • Supervision • Monitoring • Reprimand • Counseling • Pending Investigation
• Law Enforcement Entity	• Conviction for any crime (other than a minor traffic offense) • Unresolved arrests • Pending criminal charges or hearings

1)	Have any of the entities described in column I above taken any of the actions listed in column II?	☐Yes ☐No
2)	Is there any additional relevant information which is not specifically called for in the table but which in your best judgment is relevant to your application?	☐Yes ☐No
3)	Have you been convicted of any crime related to your clinical practice, including crimes involving Medicare or Medicaid?	☐Yes ☐No
4)	Have you been subjected to civil penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid?	☐Yes ☐No
5)	Have you been reprimanded or censured by a public regulatory licensing body, a public or private certifying or registering agent, a medical staff or a hospital or other healthcare facility or organization?	☐Yes ☐No
6)	Have you been found guilty of professional misconduct as defined by the laws of New York State or any other jurisdiction?	☐Yes ☐No
7)	Do you have any criminal convictions; pending criminal matters or hearings; or settlements of criminal matters?	☐Yes ☐No
8)	Do you have a medical condition (e.g., psychological or physiological condition or disorder, including substance abuse) that limits or impairs your ability to practice medicine within the scope of privileges for which you have applied?	☐Yes ☐No
9)	Do you use chemical substances—including alcohol, drugs and medications—which in any way impair or limit your ability to practice medicine with reasonable skill and safety?	☐Yes ☐No
10)	Are you currently using illegal drugs?	☐Yes ☐No
11)	Have you ever been in a supervised rehabilitation program, professional assistance program, or under the care of a physician or other professional for monitoring to ensure that you were not habitually using substances that could limit or impair your ability to exercise your privileges appropriately, or are you currently in such a program or receiving such care?	☐Yes ☐No
12)	Have there been, or are there currently pending, any medical, dental, or podiatric misconduct or malpractice claims, suits or settlements or arbitration proceedings in New York or any other state in which you are involved?	☐Yes ☐No
13)	Are there any previously successful or currently pending challenges to any licensure or registration (state or district, DEA) or the voluntary relinquishment of such licensure or registration?	☐Yes ☐No
14)	Has there been any voluntary or involuntary termination of residency training or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital or training program?	☐Yes ☐No
15)	Has the New York State Department of Health or its Office of Health Systems Management ever made a finding that you violated a patient's rights?	☐Yes ☐No

If the answer to any of the above questions is "yes," please provide a detailed explanation on a separate page.

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CONDITIONS FOR APPLICATION

By submitting this Graduate Medical Education Trainee Application ("Application") for appointment as a member of the House Staff in a hospital within the Mount Sinai Health System (the "Hospital"), I hereby:

- agree to the release of information contained in my Application to the Hospital for purposes of applying to its house staff. The information to be released includes, but is not limited to, copies of relevant registrations, certifications, diplomas, and evaluations.
- acknowledge that I have received and read the House Staff Manual of the Hospital, and will be bound by it.
- understand and agree that I, as an applicant for house staff appointment, have the burden of producing adequate information for proper evaluation of my qualifications and/or resolution of any doubts about such qualifications. I agree to cooperate fully with any quality assurance, risk management or peer-review investigation undertaken by the Hospital.
- verify that the information I provide in this Application is true, accurate and complete. I authorize the Hospital to investigate any or all statements I have made in this Application and to seek from third parties—including but not limited to hospitals, medical practitioners, schools, insurers and state agencies—verification of the information I have provided. I understand that any omissions, errors, fraudulent statements or intentional misrepresentations in this application are grounds for termination of appointment or other actions as determined by the Hospital.
- waive any confidentiality provisions concerning the information to be provided by third parties and their employees or agents to the Hospital in connection with this application, and release such third parties, their employees, or agents from any liability whatsoever for providing such information, provided that such information is provided in good faith and without malice for the purpose of this application.
- waive any confidentiality provisions and release the hospitals of the Mount Sinai Health System, their trustees, officers, employees and agents from any liability whatsoever for providing any information contained herein or in my academic files when such information is provided in good faith and without malice and upon request of an authorized representative of any other healthcare facility or any other individual or organization authorized to request such information pursuant to applicable federal, state or local law.

_____ _____

Signature **Date**

_____

Printed Name

Mount Sinai

DISCLOSURE AND CONSENT REGARDING CONSUMER REPORTS

In connection with my application to the house staff, I understand that investigative background inquiries are to be made concerning myself including consumer reports, criminal, driving and other reports. These reports may include information as to my character, creditworthiness, general reputation, personal characteristics, mode of living, habits, performance, and experience along with reasons for termination of past appointments by other facilities. I have a right to request disclosure of the nature and scope of the report, which involves personal interviews with sources such as neighbors, friends, or associates.

I authorize, without reservation, any party or agency contacted by the Hospital or its agent to furnish the abovementioned information.

_____ _____

Signature **Date**

First Name	Middle Name	Last Name

Social Security Number	Date of Birth*	Driver's License Number State

Street Address	Apt #	City	State	Country	Zip Code

* Date of Birth is requested in order to obtain accurate records.