Banner Boswell Medical Center

Family Medicine Geriatric Fellowship Program

Banner Sun Health Research Institute, 10515 W. Santa Fe Drive, Sun City, AZ 85351

Applicant's Name: ______________________________________
Last First Middle

CONTACT INFORMATION			
Desired Start Date:	**Month: Year: 20___**		
Social Security No.	___ ___	**National Provider Identifier (NPI) No.**	
Place of Birth:		**If not U.S. - Immigration status, type of visa**	
Current Mailing Address:		**Permanent Address:**	
Phone (home): **Phone (work):**		**Pager:**	
Email address:		**Date of Birth mm/dd/yyyy** (for ACGME reporting requirements,will not factor into any hiring decision)	

CURRENT POST-GRADUATE MEDICAL EDUCATION PROGRAM:			
Institution: **From:**____________ **To:** _____________	**Street Address**		
	City	**State**	**Country**
Program Director:			
Program:			

****A LETTER OF RECOMMENDATION FROM CURRENT PROGRAM DIRECTOR IS REQUIRED ALONG WITH 3 ADDITONAL PERSONAL REFERENCES ON NEXT PAGE.**

PRIOR POST GRADUATE MEDICAL EDUCATION: (List all institutions, universities, hospitals, clinics, etc. where you received training most recent first.)			
Institution: **From:**____________ **To:** _____________	**Name:**		
	City:	**State:**	**Country:**
Program Director:			
Program:			
Institution: **From:**____________ **To:** _____________	**Name:**		
	City:	**State:**	**Country:**
Program Director:			
Program:			

EDUCATION (list all medical schools attended)				
Medical School:			From:	To:
Address:	Street:		Degreee Earned:	
	City:			
	County:	State:		
Medical School:			From:	To:
Address:	Street:		Degreee Earned:	
	City:			
	County:	State:		
College or University			From:	To:
Address:	Street:		Degreee Earned:	Major:
	City:			
	County:	State:		
College or University			From:	To:
Address:	Street:		Degreee Earned:	Major:
	City:			
	County:	State:		
Other Graduate School:			From:	To:
Address:	Street		Degreee Earned:	Major:
	City:			
	County:	State:		
Secondary/High School			Graduated From:	
Address:	Street:		Degreee Earned:	Major:
	City:			
	County:	State:		

If you are a graduate of a foreign medical school, please complete the following:		
ECFMG Certificate # *(attach a copy of ECFMG Certificate)*		Date:

Exam Scores:				
National Board:	Part I:	Part 2:	Part 3:	Year(s) taken:
USMLE:	Step I:	Step 2:	Step 3:	Year(s) taken:
COMPLEX				Year(s) taken:
(Please attach transcript/documentation of scores.)				
Grants, Awards, or Scholarships				

Licenses or registrations: Indicate in which states you hold or have applied.				
If more than 2, attach a separate listing. If license not issiued, so indicate.				
State:	Lic. #	Date:	By Exam:	Or Cred:
State:	Lic. #	Date:	By Exam:	Or Cred:

Other Hospital Experiences or Employment Since Medical School Graduation:			
Facility: **From:____________** **To: _____________**	**Name:**		
	City:	**State:**	**Country:**
Postion:			
Facility: **From:____________** **To: _____________**	**Name:**		
	City:	**City:**	**City:**
Postion:			

Provide the names and address of <u>3</u> personal reference from whom you should request letters of recommendation. These should be physicians with whom you have worked closely with.				
1	Name:		Title:	Phone Number:
	Address:		City:	State: Zip:
2	Name:		Title:	Phone Number:
	Address:		City:	State: Zip:
3	Name:		Title:	Phone Number:
	Address:		City:	State: Zip:

Present membership in organizations (scientific, professional, medical staff, society, etc.)

Person to contact in case of an emergency	
Name:	**Relationship**
Address:	**City:** **State: Zip:**
Phone:	

Please answer these questions; if the answer to any of the questions is yes, a detailed report clarifying the situation must accompany this application.		
a. Has any license entitling you to practice medicine and/or surgery in any jurisdiction been refused, suspended or revoked?	**YES ______**	**NO ______**
b. Has your DEA certificate ever been refused, suspended or revoked?	**YES ______**	**NO ______**
c. Have you ever been denied membership or been subject to disciplinary proceedings in any medical organization?	**YES ______**	**NO ______**
d. Have you ever been suspended or removed involuntarily from a hospital or any institution's medical staff?	**YES ______**	**NO ______**
e. Do you have a chronic or recurring illness, or a major physical or mental disability that might limit your ability to practice your specialty?	**YES ______**	**NO ______**
f. Are you now an alcoholic and/or have you ever been treated for alcoholism?	**YES ______**	**NO ______**
g. Are you now addicted to drugs and/or have you ever been convicted or treated for drug addiction?	**YES ______**	**NO ______**
h. Have you ever been convicted of a felony?	**YES ______**	**NO ______**
i. Have you ever had malpractice or liability insurance coverage suspended or denied?	**YES ______**	**NO ______**
j. Have any claims been asserted against you alleging professional malpractice before any medical legal panel or a court of law?	**YES ______**	**NO ______**

I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of reappointment or cause for dismissal from the house staff. All information submitted by me in this application is true to my best knowledge and belief.

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By applying for appointment to the House Staff I hereby agree to appear for any interviews for my application, authorize the hospital and its representatives to consult with Administrators and members of the Medical Staffs or other hospitals or institutions with which I have been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the hospital and its representatives of all records and documents of other hospitals, professional societies and/or organizations that may be material to an evaluation of my professional qualifications and competence to carry out the privileges requested as well as my moral and ethical qualifications. I hereby release from liability the hospital and its representatives for their acts performed in good faith and without malice in connection with evaluating my application and my qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the hospital, or its Medical Staff, in good faith and without malice concerning my professional competence, character, ethics and other qualifications for medical staff reappointment and clinical privileges, and I hereby consent to release of such information.

I hereby further authorize and consent to the release of information by this hospital, other hospitals and medical associations or request regarding any information the hospital may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability Banner Boswell or Banner Good Samaritan Hospital and Medical Center and its representatives for so doing.

I understand that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.
I understand the hospital acknowledges that certain information pertaining to the condition and care of patients is confidential and, unless waived by the patient, is entitled to protection from disclosure under the law. I intend to observe the right, and nothing herein contained shall be deemed a consent by me to the waiver of such patient rights. Photocopies of this agreement shall be as binding as the original.

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Signature **Date**

WALTER J. NIERI, M.D.
Banner Family Medicine Geriatric Fellowship
Geriatric Fellowship Program Director
Banner Sun Health Research Institute
10515 W. Santa Fe Drive
Sun City, AZ 85351 (623) 815-7661 (fax) 815-2981

PLEASE INCLUDE THE FOLLOWING WITH YOUR COMPLETED APPLICATION (or sent separately as soon as possible):

- □ Copy of medical school transcripts & diploma
- □ USMLE, COMLEX or other scores
- □ Letters from 3 references you listed
- □ ECFMG certificate (if applicable)
- □ Residency completion certificate (if already completed, if not will need copy before fellowship start date)
- □ Medical School Transcripts
- □ Letter(s) from your current & any former Program Directors
- □ Curriculum vitae
- □ Personal statement regarding Geriatric Interest