BERMAN SKIN INSTITUTE

FELLOWSHIP APPLICATON

A. PERSONAL INFORMATION

Name: ____

Home Address: ____

City: __________________________ **State:** ____________________**Zip:** _________________

Home Telephone: ________________________ **Mobile Phone** __________________________

Social Security #: _________________________ **Driver's License** _______________________

Date of Birth: ____________________ **Place of Birth:** ________________________________

Citizenship: ______________________________ **UPIN Number:** _______________________

Languages spoken in addition to English: ____

B. EDUCATION

Undergraduate School: ____

Address: ____

City: _____________________________ **State:** ___________________ **Zip:**_______________

Degree:____________ **Dates Attended From (month/year):**______**To (month/year):**_______

Medical School: ____

Address: ____

City: ______________________________ **State:** __________________ **Zip:** _______________

Degree:____________ **Dates Attended From (month/year):**______**To (month/year):**_______

Internship Training Facility: ____

Address: ____

City: __________________________ **State:** ________________ **Zip:** ____________

Type of Internship: ____________________ **Program Director:** __________________

Dates Attended From (month/year): ______________ **To (month/year):**_____________

1) Residency Training Facility: ____

Address: ____

City: ___________________________ **State:** ______________ **Zip:** _____________

Type of Residency: ___________________ **Program Director:** ___________________

Dates Attended From (month/year): ______________ **To (month/year):**_____________

2) Residency Training Facility: ____

Address: ____

City: ____________________________ **State:** ______________ **Zip:** ____________

Type of Residency: ___________________ **Program Director:** ___________________

Dates Attended From (month/year): ______________ **To (month/year):**_____________

Fellowship Training Facility: ____

Address: ____

City: ____________________________ **State:** ______________ **Zip:** ____________

Type of Fellowship: ___________________ **Program Director:** ___________________

Dates Attended From (month/year): _______________ **To (month/year):**____________

C. TEACHING APPOINTMENTS

1) Institution: ____

Address: ____

City: ______________________________ **State:** _____________ **Zip:** ______________

Position: ________________ **Date From (month/year):** ______ **To (month/year):**______

D. LICENSURE/CERTIFICATION

State Medical License (Active and Inactive)

1) License Number: ____________________________ **State:** ______________________

Original Issue Date:_______________________ **Expiration Date:** __________________

2) License Number: ____________________________ **State:** ______________________

Original Issue Date:_______________________ **Expiration Date:** __________________

3) License Number: ____________________________ **State:** ______________________

Original Issue Date:_______________________ **Expiration Date:** __________________

DEA Certificate

1) Certificate Number: ___________________________ **State:**______________________

Original Issue Date:________________________ **Expiration Date:** _________________

2) Certificate Number: ___________________________ **State:**______________________

Original Issue Date:_______________________ **Expiration Date:** __________________

Board Certification

Are you currently board certified? Yes___No___

1) Specialty:____

Certifying Entity: ____

Certificate Number: _____________**Issue Date (month/year):**_______**Expiration:**_______

2) Specialty:____

Certifying Entity: ____

Certificate Number: ______________**Issue Date (month/year):**________**Expiration:**_______

Other Certifications:

Advanced Cardiac Life Support (ACLS): Yes___No___ Expiration Date:______________

Cardiopulmonary Resuscitation (CPR): Yes____No___ Expiration Date:______________

Did you graduate from a foreign medical school? Yes _____ No______

If yes, ECFMG Certificate Number: ______________________________**Date:**____________

E. WRITTEN EXAMINATIONS

List all written examinations taken. Example: National Boards, USMLE, FLEX, State Written Boards.

Examination	Location	Date

F. PROFESSIONAL ASSOCIATIONS

Do you hold membership in any professional associations and/or medical societies?
Yes_____ No_____ If "Yes", please list below.

Name	Dates

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G. HOSPITAL AFFILIATIONS (Past and Present)

1) Hospital Name: ____

Street Address: ____

City: _________________________________ **State:** ___________________ **Zip:** ___________

Privileges Status: _____________________ **Date From (mo/yr):** _______ **To (mo/yr):** ______

2) Hospital Name: ____

Street Address: ____

City: __________________________________ **State:** ___________________ **Zip:** __________

Privileges Status: ____________________ **Date From (mo/yr):** ________ **To (mo/yr):** ______

3) Hospital Name: ____

Street Address: ____

City: _________________________________ **State:** __________________ **Zip:**____________

Privileges Status: ___________________ **Date From (mo/yr):** ________ **To (mo/yr):** _______

H. PROFESSIONAL WORK HISTORY

1) Employer Name:____

Street Address: ____

City: _______________________________ **State:** ________________ **Zip:** ________________

Telephone Number: _____________________ **Contact Name:** _________________________

Position: ________________________ **Date From (mo/yr):** _________**To (mo/yr):** _________

2) Employer Name: ____

Street Address: ____

City: ___________________________ **State:** _______________**Zip:** ____________________

Telephone Number: _________________ **Contact Name:** _____________________________

Position: ______________________ **Date From (mo/yr):** _________**To (mo/yr):** __________

3) Employer Name: ____

Street Address: ____

City: ___________________________ **State:** _______________ **Zip:** ___________________

Telephone Number: _________________ **Contact Name:** ____________________________

Position: _____________________ **Date From (mo/yr):** _________**To (mo/yr):** __________

4) Employer Name: ____

Street Address: ____

City: __________________________ **State:** ________________ **Zip:** ___________________

Telephone Number: __________________ **Contact Name:** ____________________________

Position: ____________________ **Date From (mo/yr):** _________**To (mo/yr):** _________

5) Employer Name: ____

Street Address: ____

City: __________________________ **State:** __________________ **Zip:** _________________

Telephone Number: ____________________ **Contact Name:** __________________________

Position: __________________ **Date From (mo/yr):** __________**To (mo/yr):** __________

I. PROFESSIONAL LIABILITY INSURANCE

Current Carrier Name: ____

Policy Number: ____________________**Telephone Number:**___________________

Street Address: ____

City: __________________________ **State:** ______________ **Zip:** ____________

Coverage Amounts: ______________________ **Claims Made**____ **/ Occurrence**_____

Date From (mo/yr):______________**To (mo/yr):**__________________)

1) Previous Carrier Name: ____

Policy Number: ____________________**Telephone Number:**___________________

Street Address: ____

City: _____________________________ **State:** _____________ **Zip:** __________

Coverage Amounts: ______________________ **Claims Made**____ **/ Occurrence**_____

Date From (mo/yr):______________**To (mo/yr):**__________________)

2) Previous Carrier Name:____

Policy Number: ____________________**Telephone Number:**___________________

Street Address: ____

City: __________________________ **State:** ______________ **Zip:** ____________

Coverage Amounts: ______________________ **Claims Made**____ **/ Occurrence**______

Date From (mo/yr):______________**To (mo/yr):**__________________)

J. GENERAL QUESTIONS

Please provide an explanation for any "Yes" response on a separate page.

Yes No

1. ☐ ☐ Have any of your board certifications ever been suspended, revoked, or voluntarily surrendered?

2. ☐ ☐ Have you ever been named as a defendant in any criminal case?

3. ☐ ☐ Have you ever been suspended from the Medicare or Medicaid program?

4. ☐ ☐ Have you ever been disciplined, reprimanded or fined by any state board of medical examiners, professional conduct board or state or federal agency?

5. ☐ ☐ Has your license to practice medicine in any state been suspended, revoked or voluntarily surrendered?

6. ☐ ☐ Has your federal or state controlled substance license ever been suspended, revoked, or voluntarily surrendered, or has probation ever been invoked?

7. ☐ ☐ Have you ever been the subject of an investigation by any private, federal or state agency, including Professional Review Organizations concerning you participation in any private, federal, or state health program, or is any such action pending?

8. ☐ ☐ Have you ever been convicted of a felony?

9. ☐ ☐ Have your clinical privileges at any hospital or healthcare institution ever been limited, suspended, revoked, not renewed or subject to probationary or other disciplinary actions?

10. ☐ ☐ Has your request for any specific clinical privileges ever been denied or granted with stated limitations?

K. PERSONAL MEDICAL INFORMATION

1) Have you ever been denied health, life or disability insurance? Yes ___ No ___

If "Yes", please explain: ____

____

2) Do you have any physical or mental limitations (including drug or alcohol dependency) which would adversely impair your ability to practice your specialty?

Yes_____ No_____ If "Yes", please explain: ____

____

3) Are you currently taking any medications that may affect either your clinical judgment or motor skills? Yes ____ No ____ If "Yes", please provide information:

____

____

4) Are you currently under any limitations in terms of activity or work load?

Yes ____ No____ If "Yes", please provide information: ________________________________

____

5) Do you require any accommodations to be able to perform the essential functions of your specialty? Yes ___ No ___ If "Yes", please provide information: ________________________

____

6) Are you currently under the care of a physician?

Yes ___ No ___ If "Yes", please provide information:___________________________________

____

7) Have you been hospitalized for any reason within the last 5 years? Yes ____ No_____

If "Yes", please indicate date(s) and reason(s): ____

____

____

L. PROFESSIONAL REFERENCES

1) Name: _______________________________________ Specialty: ______________________
Street Address: ____
City: _____________________________ State: ______________________Zip: _____________
Telephone Number: __________________________ Fax Number: _______________________

2) Name: _______________________________________ Specialty: ______________________
Street Address: ____
City: _____________________________ State: ______________________ Zip: ____________
Telephone Number: __________________________ Fax Number: _______________________

3) Name: ______________________________________ Specialty:________________________
Street Address: ____
City: _____________________________ State: ______________________ Zip: _____________
Telephone Number: ____________________________ Fax Number: _____________________

M. ATTACHMENTS

*****Please Enclose Copies of the Following Items with the Completed Application:**

_____ Curriculum Vitae

_____ Birth Certificate

_____ State Medical Licenses (for each state licensed)

_____ DEA Certificate

_____ Specialty Board Certificate

_____ Malpractice Insurance Certificates (for each current and previous carriers)

_____ Malpractice Claim History Form (for each malpractice claim)

_____ Medical School Diploma

_____ Internship, Residency and Fellowship Certificates

_____ ECFMG Certificate (if applicable)

_____ ACLS/CPR Certification (if applicable)

N. CERTIFICATION STATEMENT

I attest and certify that I have answered the above application questions truthfully and that information given in or attached to this application is accurate and complete to the best of my knowledge.

Malpractice Claim History

Name of Provider: ____

Name of Claimant: ____

Date of Incident: ____________________________ **Date of Claim:** ________________________________

County and State where Claim was filed: ____

Nature of Allegation: ____

____

____

____

____

____

____

____

____

____

What was/is your Status?

________ **Primary Defendant**

________ **Co-Defendant**

________ **Other**

Outcome of the Case?

_________**Dismissed**

_________**Pending**

_________**Closed without Payment**

_________**Pre or Post Trial Settlement (amount: $ __________________) (date: _____/_____/_____)**

_________**Verdict for Defendant**

_________**Verdict for Plaintiff**

Name of Malpractice Insurance Carrier: ____

Address of Carrier: ____

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Policy Number: _____________________ Telephone Number of Carrier: ________________________

______________________________	____________________________________	______________
Physician Name (Print)	**Physician's Signature**	**Date**

Authorization for Release of Information

I authorize Berman Skin Institute and its authorized representatives to consult with any third party who may have information bearing on my professional qualifications (credentials), clinical competence, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on my qualifications for employment. I expressively authorize said third parties to release this information to Berman Skin Institute and its authorized representatives upon request.

I also authorize Berman Skin Institute to query the National Practitioner Data Bank and to have access to all information received with regard to any query instigated by either Berman Skin Institute or myself.

I extend absolute immunity to, release from any liability, and agree not to sue Berman Skin Institute, its authorized representatives, and any third parties for any actions, recommendations, reports, statements, communications, or disclosures involving me.

____
Print Full Name

______________________________________ ______________
Applicant's Signature **Date**

______________________________________ ______________
Witness Signature **Date**