STONY BROOK UNIVERSITY MEDICAL CENTER

MEDICAL / HOUSE STAFF SERVICES DEPARTMENT

GRADUATE MEDICAL EDUCATION CREDENTIALING INFORMATION
PDF COMPATIBLE VERSION

INSTRUCTIONS

This form is compatible with Adobe Acrobat Reader, that can be downloaded from www.adobe.com
Open this file in Adobe Reader and enter your information
Once complete, save the file with your name in the file name. GMEC_application_first_lastname.pdf
This file can be saved and edited as needed.

DETAILED INFORMATION: Please provide as much information as possible in the chronological information section (complete addresses including street names, zip codes, fax/phone numbers and email addresses). Regulatory agencies require that we primary source verify all education, postgraduate education and affiliations.

SUBMISSION OF APPLICATION

Contact your residency/fellowship coordinator for instructions on how to submit this.

MEDICAL / HOUSE STAFF SERVICES DEPARTMENT

GRADUATE MEDICAL EDUCATION CREDENTIALING INFORMATION

Stony Brook Teaching Hospitals, University at Stony Brook, Stony Brook, NY 11794-7097
PHONE: 631-444-2754 FAX: 631-444-6031

INSTRUCTIONS
1. This form must be *typed* or *printed*.
2. Include complete addresses including street names & zip codes.
3. All dates must include month and year.

DATE (MM/DD/YYYY)

1 PERSONAL INFORMATION

LAST NAME	FIRST NAME	M.I.	DEGREE
OTHER NAME(S) USED			
SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)		
CURRENT PHONE NUMBER (XXX)XXX-XXXX	ALTERNATE PHONE NUMBER (XXX)XXX-XXXX		
E-MAIL ADDRESS	NPI NUMBER		

2 PROGRAM INFORMATION

I HAVE APPLIED FOR A RESIDENCY/FELLOWSHIP POSITION IN THE FOLLOWING PROGRAM: ______

BEGINNING IN (MM/YYYY) ______

CHECK BOXES THAT APPLY

☐ RESIDENT ☐ PRELIMINARY ☐ CATEGORICAL
☐ FELLOW ☐ PRIMARY CARE

PGY LEVEL ______

NRMP CODE NUMBER ______

SUBSPECIALTY INTEREST: ☐ YES ☐ NO IF YES, WHICH ONE ______

SPECIALTY MATCH CODE NUMBER ______

3 CITIZENSHIP INFORMATION

CHECK ONE: ☐ U.S. ☐ OTHER NAME OF OTHER COUNTRY

IF YOU ARE NOT A U.S. CITIZEN, DO YOU HAVE A LEGAL RIGHT TO WORK IN THE U.S.? ☐ YES ☐ NO

STATUS: CHECK ONE: ☐ PERMANENT RESIDENT ☐ J-1 VISA ☐ EMPLOYMENT AUTHORIZATION

4 ADDRESSES

LIST ALL PLACES YOU HAVE LIVED CHRONOLOGICALLY BEGINNING WITH THE MOST CURRENT FOR THE PAST 10 YEARS. INCLUDE TEMPORARY AND PERMANENT ADDRESSES. (THIS INCLUDES ADDRESSES WHERE YOU LIVED WHILE ATTENDING SCHOOL.)

DATES	STREET ADDRESS			
______ TO ______ (MM/YYYY) (MM/YYYY)	CITY/TOWN	COUNTY	STATE	ZIP CODE

DATES	STREET ADDRESS			
______ TO ______ (MM/YYYY) (MM/YYYY)	CITY/TOWN	COUNTY	STATE	ZIP CODE

DATES	STREET ADDRESS			
______ TO ______ (MM/YYYY) (MM/YYYY)	CITY/TOWN	COUNTY	STATE	ZIP CODE

DATES	STREET ADDRESS			
______ TO ______ (MM/YYYY) (MM/YYYY)	CITY/TOWN	COUNTY	STATE	ZIP CODE

5 CHRONOLOGICAL INFORMATION

PROVIDE A CHRONOLOGICAL LISTING OF YOUR LIFE/WORK/EDUCATIONAL EXPERIENCES BEGINNING WITH UNDERGRADUATE SCHOOL. THERE MUST BE NO GAPS IN TIME. ALL TIMES MUST BE ACCOUNTED FOR. DO NOT REFER TO A SEPARATE CV. PLEASE MAKE CERTAIN TO CODE YOUR EXPERIENCES APPROPRIATELY BY REFERRING TO THE EXPERIENCE CODE TABLE SHOWN BELOW.

PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS IN TIME.YOU MUST INCLUDE ALL HOSPITAL AFFILIATIONS (PAST AND PRESENT).

*** EXPERIENCE CODE TABLE** WRITE IN THE LETTER CODE CORRESPONDING TO YOUR EXPERIENCE(S) FROM THE 9 CHOICES LISTED HERE IN THE SPACE MARKED * EXP. CODE.

EMP – Employment **GE – Graduate Education** **MS – Medical/Dental School** **UE – Undergraduate Education** **VAC – Vacation**
FEL – Fellowship **IN – Internship** **RES – Residency** **OTH – Other (Explain)**

DATES (MM/YYYY) TO	DEGREE (IF APPLICABLE)	NAME OF INSTITUTION OR EMPLOYER	
*EXP. CODE	NAME OF RESIDENCY/FELLOWSHIP	IF "OTH" EXPLAIN	CONTACT PERSON
STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4
CONTACT PHONE NUMBER (XXX)XXX-XXXX	CONTACT FAX NUMBER (XXX)XXX-XXXX	CONTACT PERSON'S E-MAIL ADDRESS	

DATES (MM/YYYY) TO	DEGREE (IF APPLICABLE)	NAME OF INSTITUTION OR EMPLOYER	
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(Continue Your Chronological Information On Page 2b

5 CHRONOLOGICAL INFORMATION (CONTINUED)

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STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4
CONTACT PHONE NUMBER (XXX)XXX-XXXX	CONTACT FAX NUMBER (XXX)XXX-XXXX	CONTACT PERSON'S E-MAIL ADDRESS	

6 LICENSURE INFORMATION

STATE LICENSURE (NUMBER & STATE)	DATE ISSUED (MM/DD/YYYY)
STATE LICENSURE (NUMBER & STATE)	DATE ISSUED (MM/DD/YYYY)
LIMITED PERMIT (NUMBER & STATE)	DATE ISSUED (MM/DD/YYYY)
DEA NUMBER	DATE ISSUED (MM/DD/YYYY)

7 EXAMINATIONS

PLEASE COMPLETE:

NAME OF TEST	DATE TAKEN (MM/YYYY)	DATE PASSED (MM/YYYY)	GRADE/SCORE	# ATTEMPTS
USMLE, Part I			Grade Average/Percentile:	
USMLE, Part II CK			Grade Average/Percentile:	
USMLE, Part II CS			☐ Pass ☐ Fail	
USMLE, Part III			Grade Average/Percentile:	
NBME, Part I			☐ Pass ☐ Fail	
NBME, Part II			☐ Pass ☐ Fail	
NBME, Part III			☐ Pass ☐ Fail	
ECFMG:			Certificate # Date of Issue:	

8 MALPRACTICE ACTIVITY

Are there any malpractice actions pending against you in this or any other state?	☐ Yes	No ☐
Have any judgements in a malpractice action been entered against you in this or any other state?	☐ Yes	No ☐
Have you entered into a settlement of any malpractice action brought against you in this or any other state?	☐ Yes	No ☐

If you answered YES to any of the above questions, please complete this section.

Plaintiff _____ Defendant(s)_____

Date of incident ____/____/_____ Date suit commenced ____/____/_____ Place of incident: _____

Status: ☐ Pending/Open ☐ Closed/Settled ☐ Abandoned (attach documentation)

If closed/settled, disposition: (attach documentation if dismissed, discontinued or verdict, no damages)

☐ Dismissed by court ☐ Discontinued by plaintiff ☐ Other _____

☐ Verdict (no damages) ☐ Verdict (damages awarded) ☐ Settled Your share: $_____

Allegations/Findings:

_____

_____

_____

_____

_____

_____

_____

_____

_____

9 PROFESSIONAL SANCTIONS/DISCIPLINARY ACTIONS (all YES answers must be explained on a separate sheet of paper)

1. Have any disciplinary actions and/or any investigations been taken, or are any in the process of being taken, which have resulted, or may result in: revocation, restriction, non-renewal, denial, suspension, reduction, limitation, termination, or *voluntary/involuntary relinquishment of clinical privileges, credentials or medical/hospital staff membership?	☐ Yes	No ☐
2. Have any actions been taken or are any in the process of being taken which have resulted in, or may result in: a fine, censure, written reprimand, non-renewal of a contract, or probation with regard to clinical privileges, credentials or medical/hospital staff membership?	☐ Yes	No ☐
3. Have you been required to: perform public service, take a course of education or training, resign, take a leave of absence, receive counseling or monitoring, with regard to your clinical privileges, credentials or membership on a medical/hospital staff?	☐ Yes	No ☐
4. Have you voluntarily or involuntarily withdrawn an application for medical/hospital staff membership or privileges?	☐ Yes	No ☐
5. Have any actions been taken which have affected or may affect your:		
• Professional licensure or certification in any state, if so, which state?	☐ Yes	No ☐
• Status on a medical or hospital staff	☐ Yes	No ☐
• Status in a professional training program	☐ Yes	No ☐
• Other professional registration/license	☐ Yes	No ☐
• Federal DEA registration (if applicable)	☐ Yes	No ☐
• Academic appointment	☐ Yes	No ☐
• Membership on any hospital or managed care organization/panel	☐ Yes	No ☐
• Participation in any third party payer program	☐ Yes	No ☐
• Participation in the Medicare/Medicaid program	☐ Yes	No ☐
• Other institutional affiliation or status	☐ Yes	No ☐
• Professional society membership	☐ Yes	No ☐
• Professional liability insurance	☐ Yes	No ☐
• Research under any federal or private grants	☐ Yes	No ☐
• Board Certification	☐ Yes	No ☐
• ECFMG, ACGME or status with any other certifying/accrediting agency	☐ Yes	No ☐
6. Have you been:		
• involved in a professional review action, sanction, disciplinary action or professional misconduct proceeding?	☐ Yes	No ☐
• found guilty of professional misconduct, as defined in the Education Law of NY State, or unprofessional conduct as defined by the NY Board of Regents, or as defined by the applicable state agency of another state?	☐ Yes	No ☐
• convicted of a felony or any act constituting a crime under NYS law, federal law or a law of another state which, if committed in this state, would have constituted a crime?	☐ Yes	No ☐
7. Have you ever pleaded guilty or been convicted of a crime or offense other than a minor traffic violation?	☐ Yes	No ☐
8. Have you ever been asked or directed to leave any program of education and/or training prior to completion?	☐ Yes	No ☐
9. Have you ever elected to leave any program of education and/or training prior to completion?	☐ Yes	No ☐
10. Are there any actions or proceedings which have involved the imposition of a sanction of suspension or dismissal from any program of education and/or training to date?	☐ Yes	No ☐
11. Is there any additional relevant information which is not specifically asked but which is relevant to your application?	☐ Yes	No ☐

*A voluntary relinquishment or voluntary nonrenewal is a disciplinary action when the relinquishment is done to avoid an adverse action, preclude an investigation or is done while the practitioner is under investigation related to professional conduct.

10 REFERENCE INFORMATION

IF YOU HAVE NOT PREVIOUSLY SUBMITTED REFERENCES, PLEASE ATTACH THE NAMES, COMPLETE ADDRESSES, E-MAIL ADDRESS AND TELEPHONE AND FAX NUMBERS OF THREE PEOPLE WE MAY CONTACT FOR A PROFESSIONAL REFERENCE.

11 PERSONAL STATEMENT

IF YOU HAVE NOT PREVIOUSLY SUBMITTED A PERSONAL STATEMENT DESCRIBING YOUR PROFESSIONAL INTERESTS, ACHIEVEMENTS AND PLANS FOR THE FUTURE, PLEASE ATTACH ONE TO THIS APPLICATION.

AUTHORIZATION FOR OBTAINING AND RELEASING INFORMATION RELEASE FROM LIABILITY

I hereby authorize Stony Brook University Hospital (SBUH), its medical staff or their representatives, to obtain information from and consult with any persons or other third party who may have information, which may be otherwise privileged or confidential, regarding, among other things, my background qualifications, credentials, clinical competence, character, ethics, behavior or any other matter relevant to the processing of my appointment.

I hereby authorize and consent to the release of information previously obtained from me, other sources, SBUH, its medical staff or their representatives to other hospitals, medical associations, the State of New York Departments of Education and/or Health, regulatory accrediting/certifying agencies or any other third party, provided such release of information is made in good faith and without malice.

I hereby release from liability all those individuals who, and/or entities which in good faith have reviewed, acted upon or provided information or documents regarding my competence, training, experience, professional ethics, character, health status and other qualifications.

I, the applicant, understand that I have the burden of producing adequate information for proper evaluation of my credentials. I agree to provide the hospital with updated, current information regarding all questions on this form. Failure to produce this information or additional information may prevent my appointment from being evaluated and acted upon.

Information given in or attached to this form is accurate. As a condition to completing this form, any misrepresentation or misstatement in, or omission from this application whether intentional or not, shall constitute cause for automatic and immediate rejection of this application resulting in denial of appointment. In the event that appointment has been granted prior to the discovery, immediate termination may result.

Upon acceptance of my personal identification and password to application resources, networking systems or wireless access to systems, maintained by Stony Brook University Hospital/HSC, I accept responsibility for their authorized use and confidentiality as set forth in Stony Brook University Hospital/HSC policies. I understand the need to maintain all information, to which I have access, in the strictest confidence. I understand that I may not share my password with anyone and to do so subjects me to discipline or loss of privileges as outlined below. I also understand that systems will be audited to track usage and access. I understand that if any unauthorized use of Stony Brook University Hospital/HSC information, system access or my password and identification are disclosed, I will be subject to appropriate disciplinary measures up to and including termination of employment or system access privileges. In addition I might be subject to possible civil and criminal fines and possible criminal prosecution under state and federal laws including but not limited to HIPAA protection of electronic health information (ePHI).

SIGNATURE **X**
DEPARTMENT
DATE (MM/DD/YYYY)

REQUIREMENTS FOR PHOTOGRAPHS:

YOU MUST SUBMIT AN **ORIGINAL** "HEAD AND SHOULDERS" **COLOR PHOTO** OF YOURSELF TO FIT THE SPACE SHOWN HERE. YOUR **ORIGINAL PHOTO** IS REQUIRED.

THE FOLLOWING ARE NOT ACCEPTABLE:

- **NO COLOR PHOTOCOPIES**
- **NO COLOR INKJET COPIES**
- **NO PREVIOUSLY PRINTED PHOTOS** (EXAMPLE: NEWSPAPER OR MAGAZINE ARTICLE)

MEDICAL STAFF SERVICES DEPARTMENT
STONY BROOK UNIVERSITY HOSPITAL, HOS 9-110
STONY BROOK, NEW YORK 11794-7097 TEL: 631-444-2754 FAX: 631-444-6031