Submit application and all required attachments to APPfellowship@imail.org

Advanced Practice Provider CARDIOLOGY FELLOWSHIP Program Application-Las Vegas

Applicant Information

Full Name: ______________________________ Date: ______________
Last *First* *M.I.*

Home Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Mobile Number: ______________________ Email: ______________________

Date of Birth: ______________ Place of Birth: ______________________

Languages Spoken (other than English): ______________________

Are you a citizen of the United States? YES NO

If no, are you authorized to work in the U.S.? YES NO

Have you ever been convicted of a crime? YES NO

If yes, explain: ______________________________

Education

Baccalaureate School Name: ______________________ Address: ______________________

From: __________ To: __________ Did you graduate? YES NO Degree: ______________

Post-Graduate School Name: ______________________ Address: ______________________

From: __________ To: __________ Did you graduate? YES NO Degree: ______________

Other Training: ______________________ Address: ______________________

From: __________ To: __________ Did you graduate? YES NO Degree: ______________

Other Training: ______________________ Address: ______________________

From: __________ To: __________ Did you graduate? YES NO Degree: ______________

Military Service

Branch: ______________________ From: __________ To: __________

Rank at Discharge: ______________________ Type of Discharge: ______________________

If other than honorable, explain: ______________________________

Malpractice History

If answer to any of the following questions is YES, please provide full details on a separate sheet. Include date of occurrence, description of events and current status.

		YES	NO
1.	Has your professional liability insurance coverage ever been terminated or denied by action of the insurance company?		
2.	Have you ever been denied professional liability insurance coverage?		
3.	Have you ever been named as a defendant or co-defendant in a malpractice action or claim?		
4.	Has any judgement or settlements been made on your behalf in professional liability cases within the last five years?		
5.	Have any professional liability suits or claims been filed against you, which are presently pending?		
6.	Have you ever been refused membership on a hospital medical staff?		
7.	Has your request for specific clinical privileges ever been denied or granted with stated limitations, or have your hospital privileges ever been suspended, revoked, or not renewed?		
8.	Have you ever resigned from a hospital staff while under investigation?		

Disclaimer and Signature

*When submitting this application, you **must** include the following items:*

- *Resume / CV*
- *Personal statement*
- *Letter of good standing from your school, or unofficial/unlocked copy of transcript*
- *Photo/headshot appropriate for a professional application*
- *Completed and signed PDF application*
- *Letters of recommendation from two of these three categories:*
  - *Work supervisor/manager*
  - *Clinical rotation preceptor*
  - *Educator/Professor (a standard dean's letter does not fulfill this category, unless the dean taught you directly for for a course, class, or semester)*

***Submit this application, and all required attachments, to: APPfellowship@imail.org.**

For the complete application timeline and information about the program, please visit: https://intermountainNV.org/fellowships.
Please contact us with questions at: APPfellowship@imail.org.

Disclosure: After completing the 12-month program, fellows transition to independent providers for two additional years. The total commitment, if accepted into the program, is three (3) years.

By signing, I agree and confirm that all of the information set forth in this application, including the attachments hereto, whether submitted by me or at my request at this time or a different time, are true and correct to the best of my personal knowledge. Material misstatements or omissions of fact concerning the matters addressed in this application, regardless of when discovered, shall constitute grounds for dismissal from Intermountain Health's APP Fellowship Program.

Applicant Signature: ______________________________ Date: ______________

Are you a former or current Intermountain Health employee or affiliate? Yes No

If you completed clinical rotations at Intermountain, list preceptors here:

Office Use Only

Date Received by GME Manager: ______________________________