



COLLEGE OF OSTEOPATHIC MEDICINE

Application for Clinical Faculty Appointment

APPOINTMENT DESIRED IN DEPARTMENT OF:

<input type="checkbox"/> Family & Community Medicine	<input type="checkbox"/> Neurology & Ophthalmology
<input type="checkbox"/> Osteopathic Manipulative Medicine	<input type="checkbox"/> Osteopathic Medical Specialties
<input type="checkbox"/> Osteopathic Surgical Specialties	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> Physical Medicine & Rehabilitation	<input type="checkbox"/> Psychiatry
<input type="checkbox"/> Radiology	<input type="checkbox"/> Other (specify _____)

NAME (last, first, middle initial): _____

PREFERRED MAILING ADDRESS: Home Office Other
 (Street/City/State/Zip) _____

SECONDARY MAILING ADDRESS: Home Office Other
 (Street/City/State/Zip) _____

BUSINESS PHONE: _____ **HOME PHONE:** _____

FAX: _____ **E-MAIL:** _____

SOCIAL SECURITY NUMBER: _____ **GENDER** MALE FEMALE

DATE OF BIRTH: _____ **NATIONAL PROVIDER IDENTIFIER (NPI) CMS TYPE 1:** _____

AOA NUMBER: _____ **AMA NUMBER:** _____

CITIZENSHIP: US Citizen Permanent Resident Non-Resident Alien Foreign National Type of Visa _____

ETHNICITY: Of Hispanic/Latino Origin Not of Hispanic/Latino Origin

PLEASE CHECK AT LEAST ONE STATUS, AS WELL AS ALL THAT APPLY:

American Indian or Alaskan Native Hawaiian PI Asian White Black or African American

PREVIOUS UNIVERSITY EXPERIENCE (Institution, position, years): _____

ANY RELATIVE EMPLOYED BY MSU? No Yes (if yes, name, relationship, title, dept _____)

CURRENT EMPLOYER: _____

EDUCATION:	Degree Earned	Major Field of Study	Institution	Year
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

INTERNSHIP: Institution _____ Start Date _____ End Date _____

RESIDENCY: Specialty _____ Institution _____ Start Date _____ End Date _____
 Specialty _____ Institution _____ Start Date _____ End Date _____

FELLOWSHIP: Specialty _____ Institution _____ Start Date _____ End Date _____

LICENSES: License Number _____ State _____ Date Issued _____
 License Number _____ State _____ Date Issued _____
 License Number _____ State _____ Date Issued _____

BOARDS: Certified? Yes No Specialty _____ Date Issued _____
 Certified? Yes No Specialty _____ Date Issued _____
 Eligible? Yes No Specialty _____ Date _____

PRIVILEGES: Hospital _____ City/State _____
Hospital _____ City/State _____
Hospital _____ City/State _____

HAVE YOU EVER BEEN INVOLVED IN THE FOLLOWING: Treated for an addiction? No Yes
Convicted for a felony? No Yes
Had your state license revoked? No Yes

If yes to any of the above, please explain _____

DID THE MEDICAL FACILITY WHERE YOU ARE PRIVILEGED AND CREDENTIALLED CONDUCT A CRIMINAL BACKGROUND CHECK (CBC) FOR YOUR EMPLOYMENT?

Yes - NAME OF HOSPITAL CBC CONDUCTED AT: _____

No

If you have not had a CBC – it is now mandatory that the department facilitate that prior to finalizing your appointment. The department will be contacting you to follow-up.

PLEASE ATTACH THE FOLLOWING ITEMS TO THIS APPLICATION:

- CV or Resume
- Copies of advanced degree(s)
- Copies of license(s)
- Two letters of professional reference

WHEN YOU SIGN BELOW, YOU ACKNOWLEDGE THAT TO THE BEST OF YOUR KNOWLEDGE THE INFORMATION PROVIDED IN THIS APPLICATION IS CORRECT.

Signature _____ Date _____

**Thank you for your interest in a clinical faculty position within the
Michigan State University College of Osteopathic Medicine.
If at any time you have questions regarding the status of your application
or the MSU College of Osteopathic Medicine,
please do not hesitate to contact MSUCOM Business Office at 517.353.5470**

PLEASE RETURN TO:

**MSUCOM Business Office
East Fee Hall
965 Fee Road, Room A317
East Lansing, MI 48824**

Or via fax 517.432.6793