CMU CENTRAL MICHIGAN UNIVERSITY | College of Medicine

Dear Physician:

We appreciate your interest in becoming a Community Educator Faculty member with Central Michigan University's College of Medicine, and are excited to collaborate with members of the medical staff that participate in the residency training programs and/or medical student clerkships.

Below is a list of required enclosures. Please return the application and supporting documents to:

Attn: Credentialing
Faculty & Staff Affairs | CMED South
Central Michigan University
2520 S. University Park Dr., Bldg. D
Mt. Pleasant, MI 48859

The following information/materials must be included with the completed application:

- Copy of Driver's license or passport
- Current CV or resume
- Copy of Professional licensure(s)
    - MI Medical Professional License
    - MI Controlled Substance License
    - DEA license
- Copy of Education certificate(s)
    - Medical school diploma
    - ECFMG certificate, if applicable
    - Internship, Residency, Fellowship certificates
- Copy of Board certification(s)
- Current malpractice insurance

The application must be completed in its entirety and submitted to the Faculty and Staff Affairs Office in order to start the academic credentialing and appointment process. **For expedited processing, you may forward your CV to our office, and your information will be pre-populated into the application.**

Thank you for your anticipated cooperation. The average processing time for a completed application packet is up to 30 days. It is the responsibility of the applicant to ensure all of the required information is provided to our office for review. If you do not have all of your required documents at this time, attach what is available and forward the remainder under separate cover as soon as possible.

Questions regarding the application process may be directed to Sarah Cresswell at (989) 774-2998, or by email at sarah.cresswell@cmich.edu.

# APPLICATION FOR FACULTY APPOINTMENT

CMU CENTRAL MICHIGAN UNIVERSITY | College of Medicine

This form should be typed or legibly printed in blank ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Return all completed applications to: Faculty & Staff Affairs | CMED South, 2520 S. University Park Drive, Bldg D., Mount Pleasant, MI 48859

If a particular field is not applicable to you, please indicate with "N/A".

## SECTION 1 – DEMOGRAPHICS

| APPLICANT INFORMATION | | | | | | | |
|---|---|---|---|---|---|---|---|
| Last Name | | First | | M.I. | | Degree(s) | |
| Other names used | | | | | | | |
| Street Address | | | | Apartment/Unit # | | | |
| City | | State | | ZIP | | | |
| Telephone Number | | E-mail Address | | | | | |
| Proposed Start Date | | Department | | Program | | | |
| Birth Date | | Birth Place | | | | | |
| Languages | | Social Security No. | | | | | |
| Specialty | | Sub Specialties | | | | | |
| Are you a citizen of the United States? | YES ☐ | NO ☐ | If no, are you authorized to work in the U.S.? | YES ☐ | NO ☐ | | |

| OFFICE INFORMATION | | | |
|---|---|---|---|
| Name of Practice/Affiliation or Clinic Name: | | Department Name | |
| Primary Office Street Address | | | |
| City | State | ZIP | |
| Office Manager | Telephone Number | Fax Number | |

## SECTION 2 – EDUCATION/CLINICAL TRAINING

| MEDICAL/PROFESSIONAL EDUCATION | | | | | | | |
|---|---|---|---|---|---|---|---|
| College or University Name | | Degree Received | | | | | |
| Address (street, city, state, zip code) | | | | | | | |
| From (MM/YYYY) | To (MM/YYYY) | Did you graduate? | YES ☐ | NO ☐ | Graduation Date | | |

| OTHER POSTGRADUATE EDUCATION (Attach additional sheet if necessary) ☐ Does not apply | | | |
|---|---|---|---|
| Institution | | Dates Attended | |
| Address (street, city, state, zip code) | | | |

| INTERNSHIP (Attach additional sheet if necessary) ☐ Does not apply | | | |
|---|---|---|---|
| Institution | | Phone Number | |
| Address (street, city, state, zip code) | | | |

| From (MM/YYYY) | | To (MM/YYYY) | | Did you complete? | YES ☐ | NO ☐ |
|---|---|---|---|---|---|---|
| Program Specialty | | Program Director | | | | |

**RESIDENCIES (Attach additional sheet if necessary)** ☐ **Does not apply**

| Institution | | Phone Number | |
|---|---|---|---|
| Address (street, city, state, zip code) | | | |
| From (MM/YYYY) | To (MM/YYYY) | Did you complete? (if NO, please explain on separate sheet) | YES ☐ NO ☐ |
| Program Specialty | Program Director | | |

| Institution | | Phone Number | |
|---|---|---|---|
| Address (street, city, state, zip code) | | | |
| From (MM/YYYY) | To (MM/YYYY) | Did you complete? (if NO, please explain on separate sheet) | YES ☐ NO ☐ |
| Program Specialty | Program Director | | |

**FELLOWSHIPS (Attach additional sheet if necessary)** ☐ **Does not apply**

| Institution | | Phone Number | |
|---|---|---|---|
| Address (street, city, state, zip code) | | | |
| From (MM/YYYY) | To (MM/YYYY) | Did you complete? (if NO, please explain on separate sheet) | YES ☐ NO ☐ |
| Program Specialty | Program Director | | |

| Institution | | Phone Number | |
|---|---|---|---|
| Address (street, city, state, zip code) | | | |
| From (MM/YYYY) | To (MM/YYYY) | Did you complete? (if NO, please explain on separate sheet) | YES ☐ NO ☐ |
| Program Specialty | Program Director | | |

## SECTION 3 – LICENSURE/REGISTRATIONS & CERTIFICATIONS

**LICENSURE**

**Physicians at CMU College of Medicine are responsible for obtaining the appropriate licensures to practice medicine in the State of Medicine and are also responsible for maintaining active and current licensure for patient care. Licensed status must be maintained for the duration of your appointment.**

| Michigan State Medical/Professional License No. | | Issue Date (MM//DD/YYYY) | | Expiration Date (MM/DD/YYYY) | |
|---|---|---|---|---|---|
| Michigan State Controlled Substance No. | | | | Expiration Date (MM/DD/YYYY) | |
| Drug Enforcement (DEA) Administration Certification No. | | | | Expiration Date (MM/DD/YYYY) | |

ALL OTHER STATE MEDICAL/PROFESSIONAL LICENSES

| State | | License No. | | Expiration Date (MM/YYYY) | |
|---|---|---|---|---|---|
| State | | License No. | | Expiration Date (MM/YYYY) | |
| ECFMG No. | | ☐ or NA | Issue Date (MM//DD/YYYY) | Valid Through (MM/DD/YYYY) | |

**BOARD CERTIFICATION (Attach additional sheet if necessary)**

**Are you board or otherwise professionally certified?**

☐ **YES** If "yes", please complete below ☐ **NO** If "No", describe your intent for certification, if any, and dates of testing for certification on a separate sheet. If you participate in a specialty which does not have board certification, please indicate on a separate sheet.

| Name of Issuing Board | Specialty | Date Certified/Recertified | Expiration Date (if any) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**OTHER CERTIFICATIONS** **ACLS, BLS, ATLS, PALS, NALS, etc.** (Attach copy of certificate if applicable)

| | | |
|---|---|---|
| Type: | Number: | Expiration Date: |
| Type: | Number: | Expiration Date: |

## SECTION 4 – PROFESSIONAL LIABILITY

**PROFESSIONAL LIABILITY CARRIER INFORMATION**

Does your current professional liability insurance cover you in all of your practice locations? ☐ YES ☐ NO

| | | | | | |
|---|---|---|---|---|---|
| Current Insurance Carrier | | | | Policy No. | |
| Address (street, city, state, zip code) | | | | | Telephone Number |
| Coverage Amount (Claim/Aggregate) | | Type of Coverage | | | Exclusions from Coverage |
| Initial Date of Coverage | | Retroactive Date of Coverage | | | Expiration Date |

Please list all of your professional liability carriers for the **past five years** (include internship, residency, fellowship programs).

| | | | | | |
|---|---|---|---|---|---|
| Name of Carrier | | | | Policy No. | |
| Address (street, city, state, zip code) | | | | | |
| Telephone Number | | From | | To | |
| | | | | | |
| Name of Carrier | | | | Policy No. | |
| Address (street, city, state, zip code) | | | | | |
| Telephone Number | | From | | To | |
| | | | | | |
| Name of Carrier | | | | Policy No. | |
| Address (street, city, state, zip code) | | | | | |
| Telephone Number | | From | | To | |

## SECTION 5 – ATTESTATION QUESTIONS

Please answer the questions "yes" or "no". **If your answer to any of the questions 2-17 is "yes", please provide full details and reasons on a separate sheet.**

An affirmative answer to any of these questions does not automatically disqualify you from an appointment at the CMU College of Medicine but may result in further follow-up or investigation for credentialing purposes.

NOTE: All information is for credentialing purposes only. Information will remain confidential and will not be shared.

| | | |
|---|---|---|
| 1) | Are you currently able, with or without reasonable accommodation, to perform delineated clinical activities and other House Staff duties? | ☐ YES ☐ NO |
| 2) | Do you have or have you ever had any license revoked, suspended, denied, restricted, limited or issued/placed in a probationary status or voluntarily relinquished? | ☐ YES ☐ NO |
| 3) | Have you ever had a DEA Certificate revoked, suspended, limited, restricted in any way or voluntarily relinquished? | ☐ YES ☐ NO |
| 4) | Have you ever voluntarily not renewed your DEA license, Medical or Dentistry License in any state? | ☐ YES ☐ NO |
| 5) | Have you ever been terminated, placed on probation or otherwise disciplined from a residency program or medical staff? | ☐ YES ☐ NO |
| 6) | Have your privileges at any hospital ever been refused, suspended, diminished, revoked or not renewed? | ☐ YES ☐ NO |
| 7) | Have you ever voluntarily withdrawn your privileges or resigned from any hospital or training program? | ☐ YES ☐ NO |
| 8) | Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization? | ☐ YES ☐ NO |
| 9) | Have you ever been named in a malpractice case? | ☐ YES ☐ NO |
| 10) | Are you now, or have you ever been, involved in Administrative, professional, or judicial proceedings in which malpractice on your part is or was alleged? (If Yes, give details including name of action or proceedings, date filed, court or reviewing agency, and the status or disposition of case concerning allegations, together with your explanation of the circumstances involved.) | ☐ YES ☐ NO |
| 11) | Have you ever been subject to disciplinary action for academic or other reason in any of the colleges, universities, graduate or professional schools you have attended? | ☐ YES ☐ NO |
| 12) | Have you ever been convicted of a crime other than minor traffic violations? | ☐ YES ☐ NO |
| 13) | Have you ever been convicted of a felony? | ☐ YES ☐ NO |
| 14) | Are you aware of any criminal charges pending or expected to be brought against you? | ☐ YES ☐ NO |
| 15) | Do you have any contagious or communicable diseases that could endanger others? | ☐ YES ☐ NO |
| 16) | Have you ever been addicted to or dependent upon intoxicating liquor, narcotics or other illegal drug substances? | ☐ YES ☐ NO |
| a) | Has this addiction ever permanently, presently or chronically impaired or distorted your judgment, behavior, or capacity to recognize reality or ability to cope with the ordinary demands of life? | ☐ YES ☐ NO |
| 17) | Are you delinquent on any Federal debt? (Include delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults on any Federally guaranteed or insured loans such as student or home mortgage loans). | ☐ YES ☐ NO |

## SECTION 6 – ATTESTATION, AUTHORIZATION AND RELEASE AND ACKNOWLEDGEMENT OF TRAINING AND EDUCATION RESPONSIBILITY

### CONSENT AND RELEASE

In applying for appointment at the CMU College of Medicine, I have read and agree to abide by its Medical Staff Bylaws. I certify that the statements in this application are true and complete and I understand and agree that misstatements or omissions in this application may be grounds for summary dismissal from the staff. I agree to immediately report any changes in the status of my medical license or any changes in my status at other hospitals, to the office of academic appointments.

I will be responsible for the medical care of the patient, for prompt and accurate completeness of medical records, for transmitting reports of the patient's condition to concerned parties who are entitled to such information, and for providing or appropriately arranging for continuity of care.

I agree to report any changes in my health status that could adversely affect my ability to practice medicine and agree, with reasonable cause, to submit to a physical examination, drug and alcohol screens and other assessments acceptable to the Executive Committee should this be considered necessary.

If I am ever under investigation by any regulatory agency (e.g., the State of Michigan Department of Consumer and Industry Services), I am responsible for immediately informing the office of academic appointments of the agency involved, the basis for the complaint and the final resolution or outcome.

I recognize ***it is my responsibility, and mine alone***, to maintain appropriate licensure at all times. I agree to abide by all rules and regulations regarding same and I realize it is unlawful to practice medicine without an active license.

I hereby authorize agents of the University to consult with other universities, hospitals and members of their medical staffs, and with licensing boards, and with anyone who may have information bearing on my competence, my character or my ethical qualification. I further authorize agents of the University to make inquiries from the said individual hospitals, boards, and courts concerning any claims, lawsuits, disciplinary actions, license restrictions or denials, or any other matters affecting my ability to practice my profession. I hereby consent to the release from any source, including information that would otherwise be privileged or confidential, to the CMU College of Medicine, of any and all information concerning my conduct and abilities to practice.

I hereby authorize and release from liability, the CMU College of Medicine and all managed care organizations or other third party payers, insofar as the University provides information from my credentialing file, including information that is confidential and/or privileged, or permits access to my file to such other organizations or payers with a need to independently evaluate or verify my credentials, or audit CMU College of Medicine's credentialing process and decisions.

I hereby release from liability all individuals and organizations that provide information concerning my qualifications for appointment. I further release from liability the CMU College of Medicine, its staff, officers and employees who make inquiries concerning my conduct and abilities to practice, and I hereby indemnify them from any claim arising from their consideration, award or denial of my application.

**I certify that the information submitted on this application is complete and correct to the best of my knowledge. I understand that any false, misleading or missing information may be cause for withdrawal of the preliminary appointment.**

Signature _____ Date: _____

Printed Name _____