**DEPARTMENT OF MEDICINE CHECKLIST**

***New Hospital / Academic Appointment, Life Number or Managed Care Enrollment***

***(MUST BE TYPED)***

|  |  |
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| **LAST NAME, FIRST NAME & DEGREE(S) (MD, DO, PhD, Etc):** |  |
| **START DATE:** |  |
| **LIFE NUMBER *(if previously or currently employed):*** |  |
| **STATUS (FULL TIME, PART TIME OR PER DIEM)** |  |
| **SALARIED OR VOLUNTARY:**  |  |
| **INCREMENTAL OR REPLACEMENT: *(If replacement, provide current/past faculty name)*** |  |
| **ACADEMIC TITLE:** |  |
| **EMAIL ADDRESS *(Personal email preferred for new salaried appointments).***  |  |
| **PRIMARY SITE:** |  |
| **MEDICINE DIVISION:****SECONDARY DEPARTMENT?:** |  |
| **DATE OF BIRTH:** |  |
| **SOCIAL SECURITY #:**  |  |
| **CONTACT#:** |  |
| **NPI#:**  |  |
| **GENDER:** |  |
| **MARITAL STATUS:** |  |
| **BOARD CERTIFICATION/ELIGIBLE: *(Include name of certifying Board and status of the certification).*** |  |
| **DOES THE CLINICAL CANDIDATE HOLD A NYS PROFESSIONAL LICENSE? Indicate: Yes or No. *(****If NO, please indicate the date that the practitioner submitted their application to the State:* |  |
| **USA CITIZEN OR PERMANENT RESIDENT (SELECT ONE):** |  |
| **VISA REQUIRED (YES OR NO)** *If yes, contact the International Personnel Office* |  |
| **COUNTRY OF BIRTH:** |  |
| **HOME ADDRESS:** |  |
| **PATIENT SERVICE ADDRESS(ES):** |  |