



**Mount
Sinai**

GRADUATE MEDICAL EDUCATION TRAINEE APPLICATION

(INTERN/RESIDENT/FELLOW/ROTATOR)

CONFIDENTIAL PROFESSIONAL INFORMATION

You have an obligation to disclose all information that may be in any way relevant to an evaluation of your application. Failure to fully disclose any potentially relevant information whether or not specifically called for in this Section, may lead to denial or loss of graduate medical education appointment. The following table is designed to assist you in determining what information is required to ensure a complete disclosure.

I. Entities	II. Actions
<ul style="list-style-type: none"> • Government Agency including: Federal, State, Local, DEA, Office of Professional Medical Conduct, Department of Education, Department of Health • Hospital or other health care facility • Practice Group including: PC, LLC, Partnership • Residency Review Committee • American Medical Association or other Professional Organization • Payers including: Managed Care Plans, Medicare, Medicaid • Specialty Boards 	<ul style="list-style-type: none"> • Censure • Termination • Suspension (regardless of whether it was stayed) • Reduction or Restriction of Privileges or Coverage (voluntary or involuntary) • Probation • Warning • Denial of Licensure, Certification or Completion • Supervision • Monitoring • Reprimand • Counseling • Pending Investigation
<ul style="list-style-type: none"> • Law Enforcement Entity 	<ul style="list-style-type: none"> • Conviction for any crime (other than a minor traffic offense) • Unresolved arrests • Pending criminal charges or hearings
<p>1) Have any of the entities described in column I above taken any of the actions listed in column II? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>2) Is there any additional relevant information which is not specifically called for in the table but which in your best judgment is relevant to your application? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>3) Have you been convicted of any crime related to your clinical practice, including crimes involving Medicare or Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>4) Have you been subjected to civil penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>5) Have you been reprimanded or censured by a public regulatory licensing body, a public or private certifying or registering agent, a medical staff or a hospital or other healthcare facility or organization? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>6) Have you been found guilty of professional misconduct as defined by the laws of New York State or any other jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>7) Do you have any criminal convictions; pending criminal matters or hearings; or settlements of criminal matters? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>8) Do you have a medical condition (e.g., psychological or physiological condition or disorder, including substance abuse) that limits or impairs your ability to practice medicine within the scope of privileges for which you have applied? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>9) Do you use chemical substances—including alcohol, drugs and medications—which in any way impair or limit your ability to practice medicine with reasonable skill and safety? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>10) Are you currently using illegal drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>11) Have you ever been in a supervised rehabilitation program, professional assistance program, or under the care of a physician or other professional for monitoring to ensure that you were not habitually using substances that could limit or impair your ability to exercise your privileges appropriately, or are you currently in such a program or receiving such care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>12) Have there been, or are there currently pending, any medical, dental, or podiatric misconduct or malpractice claims, suits or settlements or arbitration proceedings in New York or any other state in which you are involved? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>13) Are there any previously successful or currently pending challenges to any licensure or registration (state or district, DEA) or the voluntary relinquishment of such licensure or registration? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>14) Has there been any voluntary or involuntary termination of residency training or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital or training program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>15) Has the New York State Department of Health or its Office of Health Systems Management ever made a finding that you violated a patient's rights? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>If the answer to any of the above questions is "yes," please provide a detailed explanation on a separate page.</p>	

The hospitals of the Mount Sinai Health System select trainees based on their ability and without regard to race, color, creed, religion, national origin, age, gender, marital status, military status, disability, citizenship, genetic predisposition, sexual preference, or any other characteristic protected by law.



GRADUATE MEDICAL EDUCATION TRAINEE APPLICATION

(INTERN/RESIDENT/FELLOW/ROTATOR)

CONDITIONS FOR APPLICATION

By submitting this Graduate Medical Education Trainee Application (“Application”) for appointment as a member of the House Staff in a hospital within the Mount Sinai Health System (the “Hospital”), I hereby:

- agree to the release of information contained in my Application to the Hospital for purposes of applying to its house staff. The information to be released includes, but is not limited to, copies of relevant registrations, certifications, diplomas, and evaluations.
- acknowledge that I have received and read the House Staff Manual of the Hospital, and will be bound by it.
- understand and agree that I, as an applicant for house staff appointment, have the burden of producing adequate information for proper evaluation of my qualifications and/or resolution of any doubts about such qualifications. I agree to cooperate fully with any quality assurance, risk management or peer-review investigation undertaken by the Hospital.
- verify that the information I provide in this Application is true, accurate and complete. I authorize the Hospital to investigate any or all statements I have made in this Application and to seek from third parties—including but not limited to hospitals, medical practitioners, schools, insurers and state agencies—verification of the information I have provided. I understand that any omissions, errors, fraudulent statements or intentional misrepresentations in this application are grounds for termination of appointment or other actions as determined by the Hospital.
- waive any confidentiality provisions concerning the information to be provided by third parties and their employees or agents to the Hospital in connection with this application, and release such third parties, their employees, or agents from any liability whatsoever for providing such information, provided that such information is provided in good faith and without malice for the purpose of this application.
- waive any confidentiality provisions and release the hospitals of the Mount Sinai Health System, their trustees, officers, employees and agents from any liability whatsoever for providing any information contained herein or in my academic files when such information is provided in good faith and without malice and upon request of an authorized representative of any other healthcare facility or any other individual or organization authorized to request such information pursuant to applicable federal, state or local law.

Signature

Date

Printed Name



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DISCLOSURE AND CONSENT REGARDING CONSUMER REPORTS

In connection with my application to the house staff, I understand that investigative background inquiries are to be made concerning myself including consumer reports, criminal, driving and other reports. These reports may include information as to my character, creditworthiness, general reputation, personal characteristics, mode of living, habits, performance, and experience along with reasons for termination of past appointments by other facilities. I have a right to request disclosure of the nature and scope of the report, which involves personal interviews with sources such as neighbors, friends, or associates.

I authorize, without reservation, any party or agency contacted by the Hospital or its agent to furnish the abovementioned information.

Signature

Date

First Name	Middle Name	Last Name			
Social Security Number	Date of Birth*	Driver's License Number		State	
Street Address	Apt #	City	State	Country	Zip Code

* Date of Birth is requested in order to obtain accurate records.