The Mount Sinai Hospital and the Mount Sinai School of Medicine of New York University are equal employment affirmative action employers. Personnel are chosen on the basis of ability and qualifications without regard to race, color, religion, sex, age, national origin, marital status, handicap or veteran status in compliance with Federal, State and Municipal Laws.

THE MOUNT SINAI HOSPITAL

One Gustave L. Levy Place, New York, New York 10029

APPLICATION FOR HOUSESTAFF

Date of Application _____ Email Address:_____

Name _____ Social Security No. _____
First Middle Last

Mailing Address _____
Street City State Zip Beeper

Home Address _____
Street City State Zip Telephone

Check Position and Service desired { } RESIDENT (_____) { } FELLOW
PGY LEVEL

Beginning on _____ 20_____

{ } Anesthesiology	{ } Infectious Disease	{ } Physical & Rehabilitation Med.
{ } Cardiology	{ } Internal Medicine	{ } Plastic Surgery
{ } Cardiothoracic Surgery	{ } Liver Disease	{ } Psychiatry
{ } Clinical Pathology & Pathological Anatomy	{ } Medicine/Pediatrics	{ } Child Psychiatry
{ } Community Medicine	{ } Nephrology	{ } Pulmonary Disease
{ } Critical Care	{ } Neurology	{ } Radiology
{ } Dermatology	{ } Neurosurgery	{ } Radiotherapy
{ } Dental & Oral Surgery	{ } Nuclear Medicine	{ } Rheumatology
{ } Endocrinology	{ } Obstetrics/Gynecology	{ } Surgery
{ } Gastroenterology	{ } Ophthalmology	{ } Transplant Surgery
{ } Geriatrics/Adult Dev.	{ } Orthopaedics	{ } Urology
{ } Hematology/Oncology	{ } Otolaryngology	{ } Other _____
	{ } Pediatrics	

UNDERGRADUATE/ MEDICAL SCH./ 5TH PATHWAY	DATES ATTENDED	DEGREE, HONORS, AWARDS
	to	
	to	
	to	
	to	

Hospital Experience

NAME AND LOCATION	DATES ATTENDED	TYPE OF SERVICE
	to	
	to	
	to	
	to	

Over

- **On a separate sheet of paper, please list and describe any Publications and/or special work in any Medical, Dental or Allied Field.**
- **Letters of recommendation from persons under whom you have worked and studied in the institutions you have named above should be sent to the Chief of Service to whom this application is being made.**

Are you a U.S. Citizen? Yes { }
No { } If no, do you have a legal right to work in the U.S.? Yes { } No { }

If Permanent Resident state Alien # _____
(enclose copy)

If Working Visa, Visa Type and Visa # _____
(enclose copy)

SCORES FOR: USMLE I (or equivalent) _____

USMLE II (or equivalent) _____

USMLE III (or equivalent) _____

If applicable, ECFMG # _____ Valid Through _____
(enclose copy) (Expiration Date)

Are you now licensed in N.Y. State? Yes { } No { } If yes, License # _____

According to regulation, New York State and the JCAHO requires us to ask the followi ng:

Have there been, or are there currently pending, any medical misconduct or malpractice claims, suits or settlements or arbitration proceedings in New York or any other state in which you are involved? Yes { } No { }

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? Yes { } No { }

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? Yes { } No { }

Have you ever been convicted of a crime or are there any arrests or criminal proceedings currently pending against you? Yes { } No { }

Has the New York State Department of Health or its Office of Health Systems Management ever made a finding that you have violated a patient's rights? Yes { } No { }

IF THE ANSWER TO ANY OF THESE QUESTIONS IS "YES", PLEASE GIVE A COMPLETE EXPLANATION ON A SEPARATE PIECE OF PAPER.

APPLICANT'S AFFIDAVIT:

I certify that the information contained in this application is correct to the best of my knowledge. I authorize investigation of all matters contained in this application and agree that any misleading or false statements would be cause for rejection of this application or would be sufficient cause for dismissal after my appointment. I understand that my employment is contingent upon satisfactory completion of a physical examination by a Mount Sinai Employee Health Physician, the receipt by Mount Sinai of satisfactory references and my satisfactory completion of the of the probationary period of appointment for my position. I hereby authorize my present and past employers to furnish Mount Sinai with their records of service. I agree, if appointed, to supply Mount Sinai with such verifications as they are permitted by Federal, State and Municipal Codes and Regulations to request of me and to abide by all of Mount Sinai's rules and regulations.

_____ _____

SIGNATURE DATE