MONTEFIORE MEDICAL CENTER
DEPARTMENT OF OBSTETRICS & GYNECOLOGY and WOMEN'S HEALTH
POSTGRADUATE RESIDENCY PROGRAM APPLICATION
FOR PHYSICIAN ASSISTANT'S

Instructions:

1. Complete the entire application even though a resume is required. Please include a recent photograph, curriculum vitae, and personal narrative. A signature is required.

2. Arrange for three letters of reference to be sent directly to this office.

3. Have your college transcripts, PA program transcript, and clinical evaluations (rotations) forwarded to this office.

Mail application and supporting documentation to:

Joseph A. Kobeck
Montefiore Medical Center
Physician Assistant Residency Program
Department of OBSGYN & Women's Health
1300 Morris Park Avenue, Belfer 501
Bronx, NY 10461
Tel. 718-430-3204 Fax 718-430-8750

Full Name: _____
Last First M.I.

Social Security Number: _____

Permanent Address: _____

_____

E-mail address:_____

Mailing Address (If different from above):_____

_____

Date of Birth: _____ Place of Birth: _____

Citizen of (list country):_____

***If a current student or recent graduate (< 5 years), please include a letter of reference from your Program Director.**

B. Education & Certification

1. **Physician Assistant Program**

_____
Name of Program and/or School

_____
Address

_____
City State Zipcode

_____ _____
To (Month/Yr) From (Month/Yr)

_____
Credentials/Degrees Awarded

_____
Program Director

2. **List all undergraduate and graduate education**

_____
Name of Program and/or School

_____
Address

_____
City State Zipcode

_____ _____
To (Month/Yr) From (Month/Yr)

_____
Credentials/Degrees Awarded

_____

Name of Program and/or School

_____

Address

_____

City State Zipcode

_____ _____

To (Month/Yr) From (Month/Yr)

_____

Credentials/Degrees Awarded

3. **Technical/Professional**

_____

Name of Program and/or School

_____

Address

_____

City State Zipcode

_____ _____

To (Month/Yr) From (Month/Yr)

_____

Credentials/Degrees Awarded

4. **NCCPA Certification**

_____ _____

Number Year

5. **New York State Medical License**

_____ _____

Number Expiration Date

6. **Additional Training/Certification**

Program/ Location/ Date Taken/ Date Expires

_____

i.e. ACLS, BCLS, ATLS, PALS

_____

C. Professional Experience – Medical (Employment/Volunteer)

List all employment and/or volunteer experience in chronological order. Include physicians, group practices, clinics, hospitals, corporations, military, or government agencies where you served in a professional health care capacity. Attach additional sheets if necessary.

Employer	Address	Dept/Supervisor	Position	Dates From/To

D. Other Experience – Non Medical (Employment/Volunteer)

List all employment and/or volunteer experience in chronological order where you served in a non medical capacity. Identify all volunteer experience.

Employer	Address	Dept/Supervisor	Position	Dates From/To

E. Military Experience

Branch: _____

Date of Service: _____

Rank: _____

Experience & Duties: _____

_____

_____

_____

F. Professional Affiliations

List below all memberships in professional organizations or societies (local, state, or national). Attached additional sheets if necessary.

Name of Organization	Location	Inclusive Date From/To	Office Held/ Committee Work

G. Personal Health

Do you have any medical condition that impairs your ability to perform the essential functions of the position? Yes No

If yes, provide a full explanation of details on a separate sheet and attach.

H. Employment, Hospital, Institutional Actions

1. Have you ever been the subject of a hospital or institution disciplinary proceeding ? Yes No

2. At the request of a hospital or institution, have you ever voluntarily agreed to a modification or termination of your privileges ? Yes No

3. Have you ever had your employment, appointments, or privileges in a hospital or institution suspended, restricted or revoked ? Yes No

Government Actions

1. Has any government agency ever placed you on probation, suspended, revoked, taken any other action against your practice license ? Yes No

2. Have you ever been convicted of a crime ? If yes please List all convictions on a separate sheet of paper. Yes No

3. Have you ever had your DEA registration revoked ? Yes No

Professional Society Actions

1. Have you ever been subject to a medical or professional society Disciplinary proceeding or review ? Yes No

2. Have your membership in any professional organization been suspended or revoked ? Yes No

Other Professional Conduct Actions

1. Have you ever been subject to disciplinary proceeding or to a Review affection your participation in a foundation, HMO, PPO, IPA, Medicare, Medicaid, or similar entity or have you ever been notified of an intent to pursue such actions ? Yes No

2. Are there any previous and/or current pending claims, suits, settlements or arbitration procedures involving your professional practice ? Yes No

3. Has any malpractice claim settlement, not involving litigation or arbitration, ever been paid by you or on your behalf ? Yes No

Please answer YES or NO to all the above. If you answer yes to any of the above, you will be required to provide a full explanation on a separate sheet.

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 in Montefiore Medical Center (MMC) employs me. I understand that my employment is contingent upon satisfactory completion of but not limited to: a post offer physical examination by the Occupational Health Service Department; a Sterling background verification; the receipt of satisfactory work references; New York State Licensure; and my satisfactory completion of the probationary period.

I hereby authorize my present/past employers to furnish MMC with their records of my service. If employed, I authorize MMC to conduct any and all verifications as permitted by Federal, State and Municipal codes and regulations.

I hereby agree to abide by any MMC rules and regulations. I understand that my employment is not governed by any written or oral contract and is considered an "at will" arrangement. This means that I am free, as is Montefiore, to terminate the employment relationship for any or no reason, as long there is no violation of applicable Federal, State or Local Law.

Name: _____

Date: _____

Signature: _____