LOYOLA MEDICINE

Loyola University Medical Center

Graduate Medical & Dental Education
Residency/Fellowship Application
2160 South First Avenue
Maywood, IL 60153

PLEASE PRINT LEGIBLY AND COMPLETE ALL SECTIONS

PERSONAL SECTION

APPLICANT NAME LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER

CURRENT ADDRESS STREET	CITY	STATE	ZIPCODE	TELEPHONE

PERMANENT ADDRESS (if different from above) STREET	CITY	STATE	ZIPCODE	TELEPHONE

BIRTH DATE	GENDER	BIRTH PLACE	EMERGENCY CONTACT NAME:
	☐ MALE ☐ FEMALE		PHONE:

CITIZENSHIP	VISA STATUS	AAMC NUMBER

RACE :

☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN

☐ HISPANIC OR LATINO ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ CAUCASIAN

EMAIL ADDRESS:	LOYOLA RESIDENCY/FELLOWSHIP SPECIALTY:

EDUCATION SECTION - LIST ALL COLLEGES, UNIVERSITIES OR MEDICAL SCHOOL YOU HAVE ATTENDED

	SCHOOL	LOCATION (CITY, STATE)	DATES OF ATTENDANCE MM/DD/YYY FROM	TO	DEGREE EARNED
Under-graduate					
Medical or Dental School					
Graduate School					

PROFESSIONAL SECTION

IILLINOIS PHYSICIAN LICENSE NUMBER:	DATE EXPIRES:

PLEASE CHECK HERE IF YOU HAVE A PENDING APPLICATION FOR AN ILLINOIS LICENSE: ☐

DATE APPLICATION WAS SENT TO IDFPR: TEMPORARY LICENSE ☐ PERMANENT LICENSE ☐

OTHER STATE LICENSURE:	STATE:	NUMBER:	STATUS:

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FEDERAL DEA CERTIFICATE NUMBER (ATTACH COPY):	DATE EXPIRES:

NATIONAL PROVIDER IDENTIFIER (NPI) - REQUIRED

NPI NUMBER: __ __ __ __ __ __ __ __ __ __

IF YOU DO NOT HAVE AN NPI NUMBER – REGISTER IMMEDIATELY AS INDIVIDUAL PROVIDER AT:
HTTPS://NPPES.CMS.HHS.GOV/NPPES/NPIUREGISTRYHOME.DO

PLEASE CHECK HERE IF YOU HAVE A PENDING APPLICATION: ☐ **DATE APPLICATION WAS SUBMITTED:**

USMLE /COMPLEX/FMGEMS- RECORD OF EXAMINATION: EACH EXAMINATION ATTEMPT MUST BE LISTED, REGARDLESS OF WHETHER YOU PASSED, FAILED, OR WERE ABSENT. (IF ADDITIONAL SPACE IS NEEDED, ATTACH A SEPARATE SHEET)

NAME OF EXAMINATION	STATE	MONTH/YEAR	SCORES		RESULTS (PASSED, FAILED, ABSENT)
			3-DIGIT	2-DIGIT	

FOREIGN MEDICAL GRADUATE:

ECFMG CERTIFICATE #: _____ **CERTIFICATE EXPIRATION DATE:** _____

WORK HISTORY - SINCE GRADUATION FROM MEDICAL SCHOOL

PLEASE DO NOT LEAVE ANY GAPS IN THE RECORDING OF THE TIME PERIODS.
(INCLUDE RESIDENCIES, UNEMPLOYMENT, STUDYING FOR EXAM, VACATION, ETC)
IF ADDITIONAL SPACE IS NEEDED, ATTACH A SEPARATE SHEET.

PLEASE NOTE: INCLUDE COPIES OF ANY PREVIOUS US TRAINING PROGRAM CERTIFICATES. IF YOU ARE CURRENTLY ENROLLED, YOU MUST SUBMIT A COPY OF THE CURRENT TRAINING PROGRAM CERTIFICATE UPON RECEIPT BUT NO LATER THAN THE START OF YOUR LUMC TRAINING PROGRAM.

Institution Name/City State If Internship, please indicate: Residency ☐ Fellowship ☐ Specialty:	DATES OF EMPLOYMENT/ATTENDANCE From:	 To:	SUPERVISOR/PD
Institution Name/City State If Internship, please indicate: Residency ☐ Fellowship ☐ Specialty:	From:	To:	SUPERVISOR/PD
Institution Name/City State If Internship, please indicate: Residency ☐ Fellowship ☐ Specialty:	From:	To:	SUPERVISOR/PD

BOARD CERTIFICATION: (IF APPLICABLE)	
Specialty: _____ Are you board certified in your primary specialty? ☐ Yes ☐ No	If "yes", name of certifying board: _____
If "no," have you taken the specialty boards? ☐ Yes ☐ No Are you scheduled to take the specialty boards? ☐ Yes ☐ No Have you ever taken the specialty boards and failed? ☐ Yes ☐ No Date Specialty Board taken (awaiting score) _____ Date scheduled to take Specialty Board _____	Certificate number _____ Date certified (MM/DD/YYYY) _____ Date certification expires (MM/DD/YYYY) _____ Date recertified (if applicable) _____
Secondary specialty, subspecialty or added qualification _____ Are you board certified in your specialty or subspecialty? ☐ Yes ☐ No	If "yes", name of certifying board: _____ Certificate number _____
If "no," have you taken the specialty boards? ☐ Yes ☐ No Are you scheduled to take the specialty boards? ☐ Yes ☐ No Have you ever taken the specialty boards and failed? ☐ Yes ☐ No Number of years from present date required for eligibility _____ Date Specialty Board taken (awaiting score) _____ Date scheduled to take Specialty Board _____	Date certified (MM/DD/YYYY) _____ Date certification expires (MM/DD/YYYY) _____ Date recertified (if applicable) _____

PERSONAL HISTORY INFORMATION (THIS SECTION MUST BE COMPLETED BY ALL APPLICANTS)	**YES**	**NO**
Have you ever been subject to disciplinary action including suspension, termination or non-renewal?	☐	☐
Have you ever resigned a clinical training or practice position to avoid a professional review or adverse decision?	☐	☐
Do you have a medical condition, physical defect or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety?	☐	☐
Are you currently engaged in illegal use of any legal or illegal substances?	☐	☐
Do you currently overuse and/or abuse alcohol or any other controlled substances?	☐	☐
If you use alcohol and/or chemical substances, does you use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety?	☐	☐
Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse?	☐	☐
Have you ever been charged with or convicted of a crime (other than a minor traffic offense) in this or any state or country and/or do you have criminal charges pending other than minor traffic offenses in this state or any other state or country?	☐	☐
Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse?	☐	☐
Have you ever been convicted of any criminal offense including any related to healthcare fraud, in any state or in federal court (other than minor traffic violations)?	☐	☐
Have you ever been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere?	☐	☐
Have you ever been subject to governmental agency, medical or professional society disciplinary proceedings resulting in reprimand, censure, sanction or modification of your practice, or are you currently the subject of an administrative proceeding or review by any such agency or society?	☐	☐
Are you currently or have you ever been excluded, debarred, sanctioned or otherwise declared ineligible for participation in a federal or state healthcare program?	☐	☐

	YES	NO
Has your membership in any medical society or professional organization ever been denied, suspended, revoked or voluntarily surrendered in lieu of disciplinary action?	☐	☐
Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position?	☐	☐

If you answered "YES" to any of the questions listed above,
Please describe each incident in detail on a separate sheet of paper.

Certification:

I certify that all information in this application is true and no material omissions have been made. I further understand that any incorrect or incomplete information may be cause for immediate dismissal.

_____ _____
Signature Date

Attestations:

1. I acknowledge receiving the Loyola University Medical Center HOUSESTAFF HANDBOOK and agree to read and become familiar with its contents.

_____ _____
Signature Date

1. I acknowledge receiving and reading the Loyola University Medical Center PATIENT SAFETY CONTRACT.
   Therefore, I pledge:
   - to be a total advocate for patient safety,
   - to respect and honor those who intervene in the act of providing patient care when they honestly believe that the patient is at risk,
   - to always respond to an honest inquiry or intervention in a positive and supportive manner and use every experience as both a learning and teaching opportunity
   - to recognize that sometimes an observer can be mistaken, but it is better to be safe than sorry
   - to hold my colleagues to these same standards,
   - to teach these same behaviors to those with whom I interact, and
   - to report appropriate events through the appropriate safety channels : Dial SAFE-4 (Ext 72334)

_____ _____
Signature Date

_____
Name Printed

PATIENT SAFETY CONTRACT

As physicians we are committed to, not only the health and well-being of our patients, but also to their safety. Most incidents resulting in harm can be traced to complex system factors often combined with inadvertent actions by health care providers.

The most important way to reduce the risk of injury in these situations is for everyone to become active advocates for safety. That specifically means that when anybody in the system; patient, staff, nurse or physician, perceives an unsafe situation they must intervene so the incident can be averted.

To accomplish this end, it is imperative that there is a culture of continuous quality improvement attached to the issue of patient safety and that every physician becomes its champion.

LUMC Patient Safety Hotline – SAFE-4

Please print, sign and date in the spaces provided on page 4 of the Loyola Graduate Medical Education application to acknowledge receiving and reading Loyola University Medical Center's PATIENT SAFETY CONTRACT.