Office of Academic Appointments

Jack and Pearl Resnick Campus
1300 Morris Park Avenue, Belfer Room 1202
Bronx, NY 10461
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Dean's Office Approval	
Signature	Date

RESEARCH FELLOW/VISITING POST-DOCTORAL FELLOW/CLINICAL FELLOW APPOINTMENT APPLICATION

Personal Data

First Name:		Middle:	Last Name:
Gender: ☐ Male ☐ Female	Suffix:	Country of Citizenship:	Country of Birth:
Street:			Apartment #:
City:		State:	Zip Code:
Country:		Email:	
Telephone (Home):		Telephone (Cell):	
Are you legally authorized to work in the United States: ☐ Yes ☐ No			
If such authorization is temporary, please explain:			

Office Address

Institution:		
Street Address:	Building:	Room #:
City:	State:	Zip Code:
Country:	Email:	
Telephone:	Fax:	

License Information

New York State Medical License Number or Limited Permit Number:	Expiration Date:

Education (List by highest degree first)

Degree:		Date Awarded:
Medical School:		Country:
Address:	State:	Zip:

Degree:		Date Awarded:	
Graduate School:			
Address:	State:	Zip:	Country:

Degree:		Date Awarded:	
Undergraduate/Other School:			
Address:	State:	Zip:	Country:

Health Status

Are you able to perform the essential functions of the appointment as described to you, with or without accommodation? ☐ Yes ☐ No

Malpractice Activity

☐ Yes	☐ No	Are there any malpractice actions pending against you in this state or any other state?
☐ Yes	☐ No	Have any judgements in a malpractice action been entered against you in this state or any other state?
☐ Yes	☐ No	Have you entered into a settlement of any malpractice action brought against you in this state of any other state?

If you answered yes to any of the Malpractice Activity questions, please provide a full explanation:

Professional Sanctions/Disciplinary Actions

Have you ever been found to have committed (or are charges now pending that could lead to a finding that you committed) any of the following:

☐ Yes ☐ No Professional Misconduct? | ☐ Yes ☐ No Scientific Misconduct? | ☐ Yes ☐ No Conflict of Interest?

Have you ever been found to have committed (or are charges currently pending against you that could lead to finding that you committed) a discriminatory act or violation of disciplinary rules that in any way related to your past or current professional activities? ☐ Yes ☐ No

Have you ever resigned from any academic institution or health care facility in order to avoid the impositions of disciplinary measures or curtailment of privileges in any way? ☐ Yes ☐ No

Have you ever been convicted of a crime other than a motor vehicle violation, juvenile offense or matter sealed by court? ☐ Yes ☐ No

If you are a PHYSICIAN, DENTIST, PSYCHOLOGIST, or other LICENSED HEALTH PROFESSIONAL, please answer the following:

Has there ever been imposed on you or, are you currently subject to, proceedings that could lead to a denial, revocation, suspension, reduction, limitation, probation, non renewal, or involuntary relinquishment or diminution of any of the following:

☐ Yes	☐ No	Medical or other professional license/registration in any state?
☐ Yes	☐ No	DEA/Controlled substance registration?
☐ Yes	☐ No	Membership on any hospital or health care facility medical staff?
☐ Yes	☐ No	Clinical privileges at any medical facility?
☐ Yes	☐ No	Professional society membership, fellowship, or board certification?
☐ Yes	☐ No	Internship, residency, other institutional affiliation or status?
☐ Yes	☐ No	Participation in any reimbursement program?

If you have answered YES to any of the preceding questions please attach specifics on a separate piece of paper.

Failure to provide full and truthful answers is a continuing basis to invalidate this or any subsequent faculty appointment at any time.

Postdoctoral candidate signature and date required.

Signature ____________________ Date ____________________

Please send completed and signed application along with the documents listed below to the Office of Academic Appointments, Belfer Bldg., Room 1202:

1. Letter of Offer Signed by the Chair, Principal Investigator, Prospective Postdoctoral Investigator
2. Current Curriculum Vitae and Bibliography
3. Copy of Highest Degree/Diploma
4. Authorization to Release Information Form
5. As Applicable: Current New York State Medical License, ECFMG Certificate (Clinical Fellows)

DEPARTMENT RECOMMENDATION SECTION

Recommended By

Department:	Chair Name:
Signature:	Date:
Name of Training Program Faculty Advisor:	Discipline/Specialty of Proposed Training:

Recommended Title

☐ Research Fellow – In Training	☐ Visiting Postdoctoral Fellow	Clinical Fellow – In Training
Effective Date:	Payroll Source:	
If YU, include annual salary, source(s) of salary and expiration date(s) of grant(s): Annual Salary:		Sources (Index #):