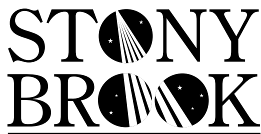

STONY BROOK UNIVERSITY HOSPITAL
Medical/House Staff Services Department

GRADUATE MEDICAL EDUCATION CREDENTIALING INFORMATION

Stony Brook Teaching Hospitals, University at Stony Brook, Stony Brook, NY 11794-7718
PHONE: 631-444-2754 FAX: 631-444-6031

INSTRUCTIONS
1. This form must be *typed* or *printed.*
2. Include complete addresses including street names & zip codes.
3. All dates must include month and year.

DATE / /

1 PERSONAL INFORMATION

LAST NAME	FIRST NAME	M.I.	DEGREE
OTHER NAME(S) USED			
SOCIAL SECURITY NUMBER	DATE OF BIRTH		
CURRENT PHONE NUMBER	ALTERNATE PHONE NUMBER		
E-MAIL ADDRESS			

2 PROGRAM INFORMATION

I HAVE APPLIED FOR A RESIDENCY/FELLOWSHIP POSITION IN THE FOLLOWING PROGRAM: ____________________

BEGINNING IN (MONTH/YEAR) ______/______

CHECK BOXES THAT APPLY

❑ RESIDENT ❑ PRELIMINARY ❑ CATEGORICAL

❑ FELLOW ❑ PRIMARY CARE

PGY LEVEL ____________

NRMP CODE NUMBER ____________

SUBSPECIALTY INTEREST: ❑ YES ❑ NO IF YES, WHICH ONE ____________

SPECIALTY MATCH CODE NUMBER ____________

3 CITIZENSHIP INFORMATION

CHECK ONE: ❑ U.S. ❑ OTHER NAME OF OTHER COUNTRY

IF YOU ARE NOT A U.S. CITIZEN, DO YOU HAVE A LEGAL RIGHT TO WORK IN THE U.S.? ❑ YES ❑ NO

STATUS: PERMANENT RESIDENT ALIEN # ❑ **OR** TEMPORARY ❑ J-1 VISA ❑

4 ADDRESSES

LIST ALL PLACES YOU HAVE LIVED CHRONOLOGICALLY BEGINNING WITH THE MOST CURRENT FOR THE PAST 10 YEARS. INCLUDE TEMPORARY AND PERMANENT ADDRESSES. (THIS INCLUDES ADDRESSES WHERE YOU LIVED WHILE ATTENDING SCHOOL.)

DATES	STREET ADDRESS			
___/___ TO ___/___ (MONTH/YR) (MONTH/YR)	CITY/TOWN	COUNTY	STATE	ZIP CODE

DATES	STREET ADDRESS			
___/___ TO ___/___ (MONTH/YR) (MONTH/YR)	CITY/TOWN	COUNTY	STATE	ZIP CODE

DATES	STREET ADDRESS			
___/___ TO ___/___ (MONTH/YR) (MONTH/YR)	CITY/TOWN	COUNTY	STATE	ZIP CODE

DATES	STREET ADDRESS			
___/___ TO ___/___ (MONTH/YR) (MONTH/YR)	CITY/TOWN	COUNTY	STATE	ZIP CODE

5 CHRONOLOGICAL INFORMATION

PROVIDE A CHRONOLOGICAL LISTING OF YOUR LIFE/WORK/EDUCATIONAL EXPERIENCES BEGINNING WITH UNDERGRADUATE SCHOOL. THERE MUST BE NO GAPS IN TIME. ALL TIMES MUST BE ACCOUNTED FOR. DO NOT REFER TO A SEPARATE CV. PLEASE MAKE CERTAIN TO CODE YOUR EXPERIENCES APPROPRIATELY BY REFERRING TO THE EXPERIENCE CODE TABLE SHOWN BELOW.

*** EXPERIENCE CODE TABLE** WRITE IN THE LETTER CODE CORRESPONDING TO YOUR EXPERIENCE(S) FROM THE 9 CHOICES LISTED HERE IN THE SPACE MARKED * EXP. CODE.

EMP – Employment	GE – Graduate Education	MS – Medical/Dental School	UE – Undergraduate Education	VAC – Vacation
FEL – Fellowship	IN – Internship	RES – Residency		OTH – Other (Explain)

DATES ___/___ TO ___/___ (MONTH/YR) (MONTH/YR)	DEGREE (IF APPLICABLE)	NAME OF INSTITUTION OR EMPLOYER	
	*EXP. CODE	IF "OTH" EXPLAIN	CONTACT PERSON
STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4
CONTACT PERSON'S PHONE NUMBER	CONTACT PERSON'S FAX NUMBER	CONTACT PERSON'S E-MAIL ADDRESS	

DATES ___/___ TO ___/___ (MONTH/YR) (MONTH/YR)	DEGREE (IF APPLICABLE)	NAME OF INSTITUTION OR EMPLOYER	
	*EXP. CODE	IF "OTH" EXPLAIN	CONTACT PERSON
STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4
CONTACT PERSON'S PHONE NUMBER	CONTACT PERSON'S FAX NUMBER	CONTACT PERSON'S E-MAIL ADDRESS	

DATES ___/___ TO ___/___ (MONTH/YR) (MONTH/YR)	DEGREE (IF APPLICABLE)	NAME OF INSTITUTION OR EMPLOYER	
	*EXP. CODE	IF "OTH" EXPLAIN	CONTACT PERSON
STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4
CONTACT PERSON'S PHONE NUMBER	CONTACT PERSON'S FAX NUMBER	CONTACT PERSON'S E-MAIL ADDRESS	

DATES ___/___ TO ___/___ (MONTH/YR) (MONTH/YR)	DEGREE (IF APPLICABLE)	NAME OF INSTITUTION OR EMPLOYER	
	*EXP. CODE	IF "OTH" EXPLAIN	CONTACT PERSON
STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4
CONTACT PERSON'S PHONE NUMBER	CONTACT PERSON'S FAX NUMBER	CONTACT PERSON'S E-MAIL ADDRESS	

DATES ___/___ TO ___/___ (MONTH/YR) (MONTH/YR)	DEGREE (IF APPLICABLE)	NAME OF INSTITUTION OR EMPLOYER	
	*EXP. CODE	IF "OTH" EXPLAIN	CONTACT PERSON
STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4
CONTACT PERSON'S PHONE NUMBER	CONTACT PERSON'S FAX NUMBER	CONTACT PERSON'S E-MAIL ADDRESS	

(Continue Your Chronological Information On Page 3

5 CHRONOLOGICAL INFORMATION (CONTINUED)

*** EXPERIENCE CODE TABLE** WRITE IN THE LETTER CODE CORRESPONDING TO YOUR EXPERIENCE(S) FROM THE 9 CHOICES LISTED HERE IN THE SPACE MARKED * EXP. CODE.

EMP – Employment
FEL – Fellowship
GE – Graduate Education
IN – Internship
MS – Medical/Dental School
RES – Residency
UE – Undergraduate Education
VAC – Vacation
OTH – Other (Explain)

DATES ___/___ TO ___/___ (MONTH/YR) (MONTH/YR)	DEGREE (IF APPLICABLE)	NAME OF INSTITUTION OR EMPLOYER	
	*EXP. CODE	IF "OTH" EXPLAIN	CONTACT PERSON
STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4
CONTACT PERSON'S PHONE NUMBER	CONTACT PERSON'S FAX NUMBER	CONTACT PERSON'S E-MAIL ADDRESS	

DATES ___/___ TO ___/___ (MONTH/YR) (MONTH/YR)	DEGREE (IF APPLICABLE)	NAME OF INSTITUTION OR EMPLOYER	
	*EXP. CODE	IF "OTH" EXPLAIN	CONTACT PERSON
STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4
CONTACT PERSON'S PHONE NUMBER	CONTACT PERSON'S FAX NUMBER	CONTACT PERSON'S E-MAIL ADDRESS	

DATES ___/___ TO ___/___ (MONTH/YR) (MONTH/YR)	DEGREE (IF APPLICABLE)	NAME OF INSTITUTION OR EMPLOYER	
	*EXP. CODE	IF "OTH" EXPLAIN	CONTACT PERSON
STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4
CONTACT PERSON'S PHONE NUMBER	CONTACT PERSON'S FAX NUMBER	CONTACT PERSON'S E-MAIL ADDRESS	

DATES ___/___ TO ___/___ (MONTH/YR) (MONTH/YR)	DEGREE (IF APPLICABLE)	NAME OF INSTITUTION OR EMPLOYER	
	*EXP. CODE	IF "OTH" EXPLAIN	CONTACT PERSON
STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4
CONTACT PERSON'S PHONE NUMBER	CONTACT PERSON'S FAX NUMBER	CONTACT PERSON'S E-MAIL ADDRESS	

DATES ___/___ TO ___/___ (MONTH/YR) (MONTH/YR)	DEGREE (IF APPLICABLE)	NAME OF INSTITUTION OR EMPLOYER	
	*EXP. CODE	IF "OTH" EXPLAIN	CONTACT PERSON
STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4
CONTACT PERSON'S PHONE NUMBER	CONTACT PERSON'S FAX NUMBER	CONTACT PERSON'S E-MAIL ADDRESS	

DATES ___/___ TO ___/___ (MONTH/YR) (MONTH/YR)	DEGREE (IF APPLICABLE)	NAME OF INSTITUTION OR EMPLOYER	
	*EXP. CODE	IF "OTH" EXPLAIN	CONTACT PERSON
STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4
CONTACT PERSON'S PHONE NUMBER	CONTACT PERSON'S FAX NUMBER	CONTACT PERSON'S E-MAIL ADDRESS	

6 LICENSURE INFORMATION

STATE LICENSURE (NUMBER & STATE)	DATE ISSUED
STATE LICENSURE (NUMBER & STATE)	DATE ISSUED
LIMITED PERMIT (NUMBER & STATE)	DATE ISSUED
DEA NUMBER	DATE ISSUED

7 EXAMINATIONS

PLEASE COMPLETE:

NAME OF TEST	DATE TAKEN	DATE PASSED	GRADE/SCORE	# ATTEMPTS
❑ USMLE, Part I			Grade Average/Percentile:	
❑ USMLE, Part II			Grade Average/Percentile:	
❑ USMLE, Part III			Grade Average/Percentile:	
❑ NBME, Part I			Pass/Fail:	
❑ NBME, Part II			Pass/Fail:	
❑ NBME, Part III			Pass/Fail:	
❑ FLEX, Component I			Score:	
❑ FLEX, Component II			Score:	
❑ ECFMG, English Test I			Expiration Date:	
❑ FMGEMS, Part I			Percent:	
❑ FMGEMS, Part II			Percent:	
❑ ECFMG:	Certificate #		Date of Issue:	

8 PROFESSIONAL SANCTIONS/DISCIPLINARY ACTIONS

Have any disciplinary actions been taken, or are any currently in the process of being taken, which resulted or may result in:revocation, censure, written reprimand, restriction, non-renewal or denial of right of privilege, suspension, fine reduction, limitation, placing on probation, required performance of public service, a course of education training, counseling or monitoring, resignation, leave of absence, withdrawal of an application, termination or non-renewal of a contract or voluntary*/involuntary relinquishment or non-renewal of any of the following? All "YES" answers require full explanation on a separate piece of paper.

1. Medical or Dental license in any state	☐ Yes	No ☐
2. Other Professional Registration/License	☐ Yes	No ☐
3. Federal DEA registration (if applicable)	☐ Yes	No ☐
4. ECFMG, ACGME or any other accrediting/certifying organization?	☐ Yes	No ☐
5. Academic appointment	☐ Yes	No ☐
6. Membership on any hospital staff	☐ Yes	No ☐
7. Clinical privileges	☐ Yes	No ☐
8. Participation in any third-party payer program	☐ Yes	No ☐
9. Participation in the Medicare/Medicaid program	☐ Yes	No ☐
10. Other institutional affiliation or status	☐ Yes	No ☐
11. Professional society membership	☐ Yes	No ☐
12. Professional liability insurance	☐ Yes	No ☐
13. Professional review action, sanction or disciplinary action	☐ Yes	No ☐

8 PROFESSIONAL SANCTIONS/DISCIPLINARY ACTIONS (CONTINUED)

14. Professional misconduct proceeding	☐ Yes	No ☐
15. Board certification	☐ Yes	No ☐
16. Research under any federal or private grants	☐ Yes	No ☐
17. Have you ever been convicted of a felony?	☐ Yes	No ☐
18. Have you ever been convicted of committing an act constituting a crime under NYS law, federal law or a law of another state which, if committed in this state, would have constituted a crime?	☐ Yes	No ☐
19. Have you ever been found guilty of professional misconduct, as defined in the Education Law of NY State, or unprofessional conduct as defined by the Board of Regents?	☐ Yes	No ☐
20. Have you ever been asked or directed to leave any program of education and/or training prior to completion?	☐ Yes	No ☐
21. Have you ever elected to leave any program of education and/or training prior to completion?	☐ Yes	No ☐
22. Are there any actions or proceedings which have involved the imposition of a sanction of suspension or dismissal from any program of education and/or training to date?	☐ Yes	No ☐
23. Have you ever pleaded guilty to or been convicted of a crime or offense other than a minor traffic violation?	☐ Yes	No ☐

*A voluntary relinquishment or voluntary non-renewal is a disciplinary action when the relinquishment is done to avoid an adverse action, preclude an investigation, or is done while the licensee is under investigation related to professional conduct.

9 MALPRACTICE ACTIVITY

Answer the following questions, and provide full details on any "YES" answer on the separate form called "MALPRACTICE ACTION SUMMARY SHEET."

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

10 REFERENCE INFORMATION

REFERENCES MUST BE SENT DIRECTLY FROM THE REFEREE TO THE PROGRAM DIRECTOR.

NAME	TITLE	PHONE NUMBER	
STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4

NAME	TITLE	PHONE NUMBER	
STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4

NAME	TITLE	PHONE NUMBER	
STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4

NAME	TITLE	PHONE NUMBER	
STREET ADDRESS	CITY/TOWN	STATE	ZIP + 4

11 PERSONAL STATEMENT

USE A SEPARATE PIECE OF PAPER TO DESCRIBE YOUR PROFESSIONAL INTERESTS, ACHIEVEMENTS, AND YOUR PROFESSIONAL PLANS FOR THE FUTURE

Medical/House Staff Services Department

NAME: ____

AUTHORIZATION FOR OBTAINING AND RELEASING INFORMATION

RELEASE FROM LIABILITY

I hereby authorize Stony Brook University Hospital (SBUH), its medical staff or their representatives, to obtain information from and consult with any persons or other third party who may have information, which may be otherwise privileged or confidential, regarding, among other things, my background qualifications, credentials, clinical competence, character, ethics, behavior or any other matter relevant to the processing of my appointment.

I hereby authorize and consent to the release of information previously obtained from me, other sources, SBUH, its medical staff or their representatives to other hospitals, medical associations, the State of New York Departments of Education and/or Health, regulatory accrediting/certifying agencies or any other third party, provided such release of information is made in good faith and without malice.

I hereby release from liability all those individuals who, and/or entities which in good faith have reviewed, acted upon or provided information or documents regarding my competence, training, experience, professional ethics, character, health status and other qualifications.

I, the applicant, understand that I have the burden of producing adequate information for proper evaluation of my credentials. I agree to provide the hospital with updated, current information regarding all questions on this form. Failure to produce this information or additional information may prevent my appointment from being evaluated and acted upon.

Information given in or attached to this form is accurate. As a condition to completing this form, any misrepresentation or misstatement in, or omission from this application whether intentional or not, shall constitute cause for automatic and immediate rejection of this application resulting in denial of appointment. In the event that appointment has been granted prior to the discovery, immediate termination may result.

SIGNATURE **X**
DEPARTMENT
DATE

CAREFULLY TAPE

A 2" x 2" PHOTO

OF YOURSELF

IN THIS SPACE

REQUIREMENTS FOR PHOTOGRAPHS:

YOU MUST SUBMIT AN ORIGINAL “HEAD AND SHOULDERS” COLOR PHOTO OF YOURSELF TO FIT THE SPACE SHOWN HERE. DO NOT STAPLE YOUR PHOTO – CAREFULLY TAPE IT IN POSITION. YOUR PHOTO IS REQUIRED FOR THIS APPLICATION TO BE CONSIDERED COMPLETE.

THE FOLLOWING ARE NOT ACCEPTABLE:

- NO COLOR PHOTOCOPIES
- NO COLOR INKJET COPIES
- NO PREVIOUSLY PRINTED PHOTOS AS FROM A NEWSPAPER OR MAGAZINE ARTICLE

STONY BROOK, NEW YORK 11794-7718 TEL: 631-444-2754 FAX: 631-444-6031