McLaren
BAY REGION

RESIDENT EMPLOYMENT APPLICATION

McLaren Bay Region is an equal opportunity employer. Applicants will receive consideration for employment without regard to race, color, sex, religion, national origin, height, weight, marital status, citizenship, handicap or age.

(PLEASE PRINT IN BLACK INK)

PERSONAL

Last Name First Name Middle Name

Address NumberStreet Apt# City State ZIP Code

E-mail Address

Telephone Number(s)
Home: _____ Best time to call: _____
Work: _____ May we contact you at work? ρ Yes ρ No

Social Security Number

Are you 18 years old or older? ρ Yes ρ No Are you a U.S. citizen? ρ Yes ρ No

Are you legally eligible to work in the U.S.? ρ Yes ρ No AOA#: _____

EDUCATION

	Name and Location	#of Years Completed	Diploma and Degree	Courses of Study
College				
Under Graduate				
Medical School				

Are you currently (or eligible to be): Certified? ρ Yes ρ No Licensed? ρ Yes ρ No
If yes: In Michigan? ρ Yes ρ No Number: Exp Date: _____
Any Other State? _____ Number: Exp Date: _____

MILITARY

Have you had any experience in the Armed Forces of the United States? ρ Yes ρ No
If yes, what branch?
Discharge date: _____ Rank at discharge:
Are you in the reserves? ρ Yes ρ No If yes, date obligation ends: _____
List any special

HEALTH

Do you have any contagious or communicable disease that is a direct threat to the health or safety of others in the workplace?
ρ Yes ρ No If yes, explain on separate sheet.
Immunization dates: MMR _____ Hepatitis B _____ TB Test _____

CLINICAL REFERENCES

Please give the names and addresses of three physicians who can comment authoritatively regarding your professional qualifications, relevant training or experience, current competence, and ability to perform the privileges requested, and may be contacted by the Medical Education Department. One of the references must be the Program Director and DME from your most recent hospital appointment.

1					
	(Name)	(Address)	(ZIP Code)	(Phone)	(No. Years Known)
2					
	(Name)	(Address)	(ZIP Code)	(Phone)	(No. Years Known)
3					
	(Name)	(Address)	(ZIP Code)	(Phone)	(No. Years Known)

PROFESSIONAL INFORMATION

Date of Family Practice Residency desired: _____ Date of Intern Graduation:
Anticipated state(s) of practice:_____ Residency Plans:

_____

Professional memberships, past and present (complete on separate sheet, if necessary) - Medical societies:

_____

ADDITIONAL INFORMATION

Have you ever been convicted of a crime? ρ Yes ρ No
If yes, when, where and nature of offense:

_____

(A conviction will not necessarily bar you from employment. Each conviction will be judged on its own merits with respect to time and seriousness. All circumstances will be considered.)

Have you ever been covered by a surety bond? ρ Yes ρ No

Have you ever been denied surety bond coverage or had surety bond coverage revoked? ρ Yes ρ No
If yes, explain: _____

Have you ever had or do you currently have a malpractice case or judgment pending against you? ρ Yes ρ No
If yes, please state details on a separate sheet and include date, name, court in which filed.

Has your license to practice medicine in any jurisdiction ever been suspended, revoked, or not ρ Yes ρ No
If yes, please state details on a separate sheet.

Has your staff membership status or privileges at any hospital or other health care institution ever been revoked, suspended, reduced, not renewed, or otherwise involuntarily suspended? ρ Yes ρ No
If yes, please state details on a separate sheet.

Have you ever been denied membership, or renewal thereof, or been subject to disciplinary proceedings ρ Yes ρ No
If yes, please state details on a separate sheet.

REQUIRED INFORMATION

1. University Transcript - Official Copy & Copy of Diploma
2. National Board Scores - Parts I, II, & III
3. Dean's Letter & Letter from D.M.E.
4. ACLS and BCLS Certification
5. Copy of MI License, DEA (if applicable)
6. Dates & Place of Internship - Copy of Certificate
7. Curriculum Vitae

APPLICANT'S AUTHORIZATION AND UNDERSTANDING

I represent to McLaren Bay Region that all of the information provided by me now or in the future in support of my application for employment is true and complete. If hired, I agree that any false information, misrepresentation or material omission provided by me in this application or in support of my application may result in discipline or discharge.

I hereby grant permission and consent for McLaren Bay Region and/or its designee, to obtain and verify information about my professional education, training, licensing, competence, ethics, character and other qualifications. I consent to the release of such information, whether in the form of transcripts, records, tapes, letters, photocopies and/or duplication of any of the foregoing, and/or verbal statements, by Hospital Administrators, Director(s) of Medical Education, Residency Program Director(s), of programs in which I have served, state licensing or regulatory bodies (by whatever name known in their respective jurisdiction(s), physicians, clinics, or other individuals or organizations who or which possess information about me. Such information may be released to McLaren Bay Region or to its representatives.

I hereby release from liability and agree to hold harmless all employees, agents and representatives of McLaren Bay Region and/or its designees, for their acts performed and statements made in connection with obtaining, reviewing, and evaluating my credentials and qualifications. I further acknowledge that my cooperation by consenting to the production of such information about me does not guarantee that McLaren Bay Region and its designees will contract me. The determination of whether I am qualified to serve as an Intern/Resident is the reason such information is needed for review and evaluation by McLaren Bay Region and/or it designees.

I further agree that a photocopy of this document will serve as a duplicate original.

I understand I will be required to undertake a physical examination, which includes a drug and alcohol screen, in connection with my application for employment. The examination would be conducted by a physician or clinic selected by the Medical Center. I hereby authorize any such physician or clinic to release such information derived from that examination to the Medical Center. I waive any claim that I might have on account of such information being provided to the Medical Center.

I certify that if am legally authorized to work in the United States. I understand that any offer of employment is conditional upon my providing documents that prove both my identity and my authorization to work in the United States. I further understand that my failure to produce such documents will result in the revocation of the offer or the termination of employment.

I understand that McLaren Bay Region will accommodate, to the extent required by law, handicapped employees in order to allow access to Medical Center Facilities and employment opportunities. I further understand that I have 182 days from this date or the date on which I know and reasonably should know that I need such an accommodation to file with McLaren Bay Region a written request for such accommodation.

Print Name: _____

Signature: _____ Date: _____

Affiliated with
MICHIGAN STATE UNIVERSITY
COLLEGE OF OSTEOPATHIC MEDICINE

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