Application for Clinical Fellowships in Oncology

INSTRUCTIONS • PLEASE READ CAREFULLY.
PLEASE TYPE OR PRINT LEGIBLY

1 **Application Form.** The application is complete only if it includes all four pages and the applicant's original signature (no copies) on page 4.

2 **Personal Statement (page 1):** Program directors want to know about your professional interests, achievements and plans for the future. Reference should be made to research experience and training, special projects or scientific work you have engaged in and any notable professional accomplishments you have achieved. Bibliographic references should be provided for all published papers.

3 **Photograph (page 2):** Because of the number of applicants interviewed by each program, program directors require a photograph in order to identify individuals with whom they have spoken during the selection process. Space is provided for the attachment of a recent 2" x 2" photograph.

4 **Month/Year of Graduation:** If your medical education was interrupted for any reason, you should explain the circumstances in the Personal Statement.

5 **Interview Scheduling (page 4):** Indicate the general time period or specific date(s) that you are able to appear for an interview.

6 **References (page 4):** It is the applicant's responsibility to ensure that all letters of recommendation are received by the Institute. Most programs require a minimum of three (3) letters of recommendation. References should be faculty members who know you well and are in a position to comment on your suitability for the position you seek. Photocopies are not acceptable.

7 **LICENSURE:** New York State law requires that all Fellows have either a New York State Medical License or a Limited Permit. Application forms and instructions are available from:
State Board for Medicine
State Education Department
Empire State Plaza Cultural Education
Albany, New York 12230
or at www.op.nysed.gov

8 **If accepted,** you also will be required to provide the following:
- Copy of New York State Medical License or Limited Permit
- Copy of Medical School Diploma
- Verification of completion of residency training
- ECFMG, if applicable
- List of credentials and privileges you presently hold

9 **Mail complete application to the appropriate Department at:**
Roswell Park Cancer Institute
Elm and Carlton Streets
Buffalo, New York 14263

Application for Fellows

1) **NAME** LAST FIRST MIDDLE SOCIAL SECURITY NUMBER

BEGINNING ON MONTH DAY YEAR
(Type or Print: black ink is preferred)

2) **I am applying to the following specialty program**

3) **Personal Statement** **(see instructions; Use additional sheet if necessary)**

4) Name LAST FIRST MIDDLE SOCIAL SECURITY NUMBER

5) Address

6) City State Zip

7) Phone HOME WORK MESSAGE

8) e-mail

9) Citizenship
❒ U.S.
❒ Other (specify):

Visa Status (if applicable)
❒ Permanent
❒ Temporary (specify):

Attach
Recent Photograph
(2" x 2")

10) Have you worked for this Institute before? ❒ Yes ❒ No (If under different name, please indicate)

11) Educational History

Enter the names of all post-secondary institutions attended (beginning with the most recent). Enter the institution name, its location, dates of attendance, major field of study, the exact name of the degree received and the date of degree.

Name of Institution	Location (City and Country)	Dates of Attendance From To	Major Field	Degree Received	Date of Degree

12) Are you licensed or have you ever been licensed as a physician in any other state or country? ❒ Yes ❒ No

State or Country	Date License Issued	Number	Basis of Licensure			Any Limitations on License
			Examination (Date Passed)	Endorsement	Other	

13) Pease check all the examination combinations below that you have successfully completed:

EXAMINATION COMBINATIONS

❒ USMLE STEPS 1, 2, 3

❒ FLEX Parts I, II, and III

❒ FLEX Components I and II

❒ NBME Parts I, II, and III

❒ NBME Parts I and II and USMLE Step 3

❒ NBME Part I, USMLE Step 2 and NBME Part III

❒ NBME Part I, and USMLE Steps 2 and 3

❒ USMLE Step 1 and NBME Parts I and II

❒ USMLE Step 1, NBME Part II, and USMLE Step 3

❒ USMLE Steps 1 and 2 and NBME Part III

❒ USMLE Step 1, NBME Part II, and FLEX Component II

❒ NBME Part I, USMLE Step 2, and FLEX Component II

❒ USMLE Steps 1 and 2 and FLEX Component II

❒ NBME Parts I and II and FLEX Component II

❒ FLEX Components I and USMLE Step 3

❒ NBOME Parts I, II, and III

❒ Other: _____

Date examination sequence was completed _____

14) Experience

START WITH YOUR PRESENT OR LAST EMPLOYMENT AND WORK BACK.
(Be sure to include internships, residencies, fellowships):

NAME OF HOSPITAL OR INSTITUTION	TELEPHONE NUMBER ( ) FROM MO/YEAR TO MO/YEAR
ADDRESS CITY STATE ZIP	TITLE
NAME AND TITLE OF IMMEDIATE SUPERVISOR	DUTIES
REASON FOR LEAVING	

NAME OF HOSPITAL OR INSTITUTION	TELEPHONE NUMBER ( ) FROM MO/YEAR TO MO/YEAR
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NAME AND TITLE OF IMMEDIATE SUPERVISOR	DUTIES
REASON FOR LEAVING	

15) Board Certification

Please attach documentation verifying current certification or eligibility.

Status and Year

Board Name	Certified	Recertified	Qualified for Exam (Until when?)

Have you ever taken and failed a certification examination? ❒ YES ❒ NO
If yes, please provide details.

Interview Scheduling

❒ The following general time period(s) is most convenient to me: From To _____

❒ I am able to schedule an interview on the following specific date: _____

❒ I am not able to come for an interview

Professional Liability

Have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice? If yes, please provide list and status on separate sheet. ❒ YES ❒ NO

Comments: _____

Disciplinary Actions

Have any of the following ever been, or are any currently in the process of being, denied, revoked, suspended, reduced, placed on probation, not renewed, or voluntarily relinquished? If yes, please provide full explanation on a separate sheet.

Medical license in any state	❒ YES ❒ NO
Other professional registration/license	❒ YES ❒ NO
DEA registration	❒ YES ❒ NO
Academic appointment	❒ YES ❒ NO
Membership on any hospital medical staff	❒ YES ❒ NO
Clinical privileges	❒ YES ❒ NO
Perogatives/rights on any medical staff	❒ YES ❒ NO
Other institutional affiliation or status threat	❒ YES ❒ NO
Professional society membership or fellowship/Board certification	❒ YES ❒ NO
Professional office	❒ YES ❒ NO
Any other type of professional sanction	❒ YES ❒ NO
Professional liability insurance	❒ YES ❒ NO
Have there been any felony criminal charges brought against you in the last 5 years?	❒ YES ❒ NO
Have you been convicted of any crimes?	❒ YES ❒ NO

Health Status

(If any of the following questions are answered in the affirmative, please provide full explanation on a separate sheet.)

Do you presently have a physical or mental health condition, including alcohol or drug dependence, that affects or is reasonably likely to affect your ability to perform professional or medical duties appropriately?	❒ YES ❒ NO
Are you currently under care for a continuing health problem?	❒ YES ❒ NO
Have you at any time during the last five years been hospitalized or received any other type of institutional care for a health problem?	❒ YES ❒ NO

COMMENT: _____

_____

References

Name three individuals who have personal knowledge of your current clinical abilities, ethical character, health status, and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from the Hospital and Medical Staff authorities. The named individuals must have acquired the requisite knowledge through observation of your professional practice over a reasonable period of time and, at least one must have had organizational responsibility for your performance.

Name Title Address

_____

_____

_____

Signature

I hereby certify that to the best of my knowledge and belief, I have no physical or mental illness or mental defect which interferes with my professional appointment. All information submitted by me in this application is true and accurate to my knowledge and belief.

I understand that employment is contingent upon being able to pass a physical examination, and I agree to submit to one by a physician of the Institute choice.

I hereby authorize the release of any information regarding my previous employment record to Roswell Park Cancer Institute.

Date: _____ Signature: _____