
Application for Clinical Fellowships in Oncology

The logo watermark is a stylized, light gray graphic. It features a central vertical line with a registered trademark symbol (®) at its base. To the right of this line, there are several curved, overlapping shapes that resemble a stylized building or a series of arches. The text 'ROSWELL PARK CANCER INSTITUTE' is overlaid on the left side of this graphic.

**ROSWELL
PARK
CANCER
INSTITUTE**

4) Name LAST FIRST MIDDLE SOCIAL SECURITY NUMBER

5) Address

6) City State Zip

7) Phone HOME WORK MESSAGE

8) e-mail

9) Citizenship Visa Status (if applicable)
 U.S. Permanent
 Other (specify): 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) Please check all the examination combinations below that you have successfully completed:
EXAMINATION COMBINATIONS

<input type="checkbox"/> USMLE STEPS 1, 2, 3	<input type="checkbox"/> USMLE Step 1, NBME Part II, and USMLE Step 3
<input type="checkbox"/> FLEX Parts I, II, and III	<input type="checkbox"/> USMLE Steps 1 and 2 and NBME Part III
<input type="checkbox"/> FLEX Components I and II	<input type="checkbox"/> USMLE Step 1, NBME Part II, and FLEX Component II
<input type="checkbox"/> NBME Parts I, II, and III	<input type="checkbox"/> NBME Part I, USMLE Step 2, and FLEX Component II
<input type="checkbox"/> NBME Parts I and II and USMLE Step 3	<input type="checkbox"/> USMLE Steps 1 and 2 and FLEX Component II
<input type="checkbox"/> NBME Part I, USMLE Step 2 and NBME Part III	<input type="checkbox"/> NBME Parts I and II and FLEX Component II
<input type="checkbox"/> NBME Part I, and USMLE Steps 2 and 3	<input type="checkbox"/> FLEX Components I and USMLE Step 3
<input type="checkbox"/> USMLE Step 1 and NBME Parts I and II	<input type="checkbox"/> NBOME Parts I, II, and III
	<input type="checkbox"/> 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
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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ADDRESS CITY STATE ZIP	TITLE		
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

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

Scheduling

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: _____