The Panamerican Trauma Society
INTERNATIONALL FELLOWSHIP PROGRAM
From the US- to Latin America
Education Committee

To be completed by fellow applicant

***(Submit this form with all paperwork requirements** to the appropriate Program Coordinator for processing.*
***Incomplete and illegible forms will be returned** and will delay your approval (i.e., no DEA # put N/A).)*

Name of Rotating Fellow: (**Please print**)_____

Home Address: _____
Address City/State/Zip

E-Mail Address: _____

Home #: [_____]_____ Work #: [_____]_____Cell #: [____] _____

DOB:_____ SS#:_____ Male / Female *(Please circle one)*

PGY Level:_____ NPI#:_____ DEA #: _____

Current Home Institution: _____
Mailing Address City/State/Zip

Current Program Director's Name & E-Mail Address: _____
Name E-Mail Address

Medical School: _____
Name/City/State or Name/Country/Providence

Medical School Graduation Date (Month/Year):_____ Initial Program: _____

Emergency Contact Information:

In the event of an emergency, please contact: _____
Name Relationship to Self

Address (City/State/Zip): _____

Phone #: [_____]_____Alternate Phone #: [_____] _____

PTS Program & Program Director's Name: _____&_____

Requested Fellowship Dates: **From:**_____ **Through:** _____

Purpose of Fellowship:_____(Please attach additional information if necessary)

The information provided for this fellowship is true. I agree to provide other documents required for this fellowship no later than 60 days before my rotation begins.

_____ _____
Rotating Resident/Fellow Signature **Date**

SUPPLEMENTAL APPLICATION FORM

Please print or type all information.

Name_____ Social Security No._____

Training Program _____

Please respond to the following questions. If you answer YES to any of these questions, except for question #1a, you must provide a full explanation of the details on a separate sheet, including date, place, reason, and disposition of the matter, as well as other, relevant information.

	YES	NO
1. Health Status:		
a. If you perform invasive procedures, have you complied with the U.S. Public Health Service recommendation to know your health status regarding blood borne pathogens such as hepatitis B and human immunodeficiency virus?	____	____
b. Do you currently suffer from any physical, mental, emotional, or any condition, which affect, or are likely to affect, your ability to perform your duties as a fellow member or which may place a patient at risk? If so, please provide a letter from your treating professional to include diagnosis, treatment, prognosis, and fitness to practice.	____	____
c. Do you take any medication or drugs (including alcohol or any form of drug, legal or illegal) which affect, or is likely to affect your ability to perform your duties as a fellow member or which may place a patient at risk?	____	____
d. Have you ever been physically or emotionally dependent upon the use of alcohol/drugs or treated by, consulted with, or been under the care of a professional for any substance abuse? If yes, please provide a letter from the treating professional.	____	____
e. Do you have an impairment for which you will request accommodations in order to perform your responsibilities?	____	____
2. Have you ever been denied clinical privileges by or appointment to any health care facility or managed care entity?	____	____
3. Has your membership status or clinical privileges by another health care facility or managed care entity ever been revoked, suspended, limited, reduced, and/or not renewed?	____	____
4. Has your membership in a local, state, or national medical society or other professional society ever had been suspended, terminated, or denied?	____	____
5. Has any state or federal licensing entity revoked, suspended, limited, or denied a certificate or license to you or taken any other disciplinary action?	____	____
Please attach a copy of your current medical license.		
6. Have you ever voluntarily or involuntarily relinquished your professional license (including DEA), any or all clinical privileges, or membership in a medical society or association: a. While under investigation by the health care entity, or b. In return for not conducting such investigation or proceeding?	____	____
7. Has your narcotic license ever been revoked, suspended, or limited in any way?	____	____
8. Have you ever been denied a DEA registration number or been issued a restricted registration?	____	____

If currently registered, give number and state of issue.

DEA Number_____ State of Issue_____ Expiration date_____

State Pharmacy Number_____ Expiration date_____

	YES	NO
9. Malpractice information:		
a. Have you ever had a malpractice claim filed against you or is a claim currently pending against you?	____	____
b. Has a lawsuit ever been settled on your behalf?	____	____
c. Has a verdict ever been rendered against you in a malpractice lawsuit?	____	____
d. Have you ever been denied professional liability coverage?	____	____

If yes to 9a.-9c., please provide a letter from the attorneys who are/were assigned to represent you in the malpractice actions. The letter must address: current status of malpractice case, physician's role in alleged negligent actions, whether expert reviews of the physician/s care have been obtained and the general substance of those reviews, and anticipated trial date or expectation of settlement. If yes to 9d., please provide a letter from the carrier explaining reasons for denial of coverage.

10. Have you ever been suspended, excluded, or debarred from participation or otherwise sanctioned or had civil monetary penalties levied against you by a Medicare, Medicaid, or other Federal program?	____	____
11. Have you ever been convicted, entered into a plea bargain, or pled Nolo Contendere to a felony, crime of moral turpitude, healthcare fraud or other crime related to governmentally financed healthcare programs, or criminal abuse or neglect of patients?	____	____
12. Do you currently have clinical privileges at any other institution(s)? If yes, please provide name and address of institution(s).	____	____

Should the answer to any of these questions change, I understand that I am under a continuing obligation to notify the PTS and hosting organization of such change or changes in writing so long as I remain a member of the Housestaff.

I hereby make application for appointment to the Housestaff of the Virginia Commonwealth University Health System. I understand and agree that as an applicant for Housestaff membership, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications. I fully understand that any significant misstatements in or omissions from this application constitute cause for denial, modification, suspension, or revocation of my appointment and/or clinical privileges. I certify that to the best of my knowledge and belief all information provided in this application is true, correct, and complete.

Further, should reasonable question exist regarding my physical or mental ability to perform the privileges granted, I agree to undergo a mental or physical examination, if requested. Should the examination provide evidence of mental or physical impairment, I understand it is my burden to show reasonable evidence that the impairment does not interfere with my professional competence.

In making this application, I understand, and agree, that in applying for clinical privileges in the Virginia Commonwealth University Health System. I agree to the release of my credentialing by the Graduate Medical Education Office and its staff for such purposes where required by contract with one of these entities and/or where requested or endorsed by the Health System in accordance with established policy. My credentialing information may be released only for the purpose of my being credentialed by such third party contractors under an institutional contract or for credentialing by an arm of the University, unless otherwise explicitly authorized by me in writing. All reasonable effort will be made to maintain this information as confidential and to preserve any legal privilege afforded the information.

If granted, I agree, as a member of the Housestaff of the Virginia Commonwealth University Health System, to abide by the established practices, procedures, and policies of the Health System and those of its programs, clinical departments, and other institutions to which I may be assigned. Further, I pledge to maintain an ethical practice, abiding by the ethical principles set forth by the American Medical Association, with my patience's interest at the center of the care I render.

Signature of Applicant_____Date of Application_____

RELEASE OF INFORMATION

By applying for the PTS International Felowship Program, I hereby authorize the PTS and the hosting organization overseas and their representatives to consult with Administrators and members of Medical Staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to the inspection by the hospital, its Clinical Staff, and its representatives of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the duties of a Housestaff member, as well as my moral and ethical qualifications and staff membership.

I understand and agree that I, as an applicant for Housestaff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.

I hereby release from liability all representatives and staff of the Panamerican Trauma Society for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability all individuals and organizations who provide information to the Health System, or its Clinical Staff, in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for housestaff appointment, and I HEREBY CONSENT TO THE RELEASE OF SUCH INFORMATION. I further release PTS from liability for their use of the information they gather in the process.

It is my understanding that a copy of this Release of Information will be provided to each individual, hospital, or organization where information on my credentials is sought in writing, and that the original of this document shall be kept on file in the PTS HQ office.

_____ _____

Name (please print) Training Program

_____ _____

Signature Date