**APPLICATION INFORMATION**

Name Last/First/MI\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address/City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone/email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LICENSURE INFORMATION**

State \_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_Full \_\_\_\_ \*Limited\_\_\_\_ License Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
State \_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_Full \_\_\_\_ \*Limited\_\_\_\_ License Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
State \_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_Full \_\_\_\_ \*Limited\_\_\_\_ License Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\*If limited, please explain on a separate document.

**EDUCATION AND TRAINING**

|  | **Institution/Company** | **City/State** | **Dates at Institution/Company** | **Degree** |
| --- | --- | --- | --- | --- |
| College |  |  |  |  |
| Medical School |  |  |  |  |
| Internship |  |  |  |  |
| Residency |  |  |  |  |
| Fellowship |  |  |  |  |
| Work Experience |  |  |  |  |

Are you a U.S. Citizen? Yes [ ]  No [ ]
If no, what is your current visa status?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Are you ECFMG? Yes [ ]  N/A [ ]
ECFMG Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BOARD CERTIFICATIONS**

Board Certified Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Board Eligible Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Planned\_\_\_\_\_\_\_\_\_\_\_\_\_\_

USMLE or COMLEX – Part III Date Passed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

USMLE Scores: Please arrange for the National Board of Medical Examiners to send an official copy of your United States Medial Licensing Exam (USMLE) steps I, II, and III score(s). If you are enrolled in an AAMC approved medical school in the US or Canada, we will accept a copy of your school’s report of your scores provided it is verified as a true copy by the registrar and stamped with the school seal.

COMLEX Scores: Please arrange for the American College of Osteopathic Family Physicians to send an official copy of your Comprehensive Osteopathic Medical Licensing Examination steps I, II, and III score(s). If you are enrolled in an AAMC approved medical school in the US or Canada, we will accept a copy of your school’s report of your scores provided it is verified as a true copy by the registrar and stamped with the school seal.

**PROFESSIONAL QUESTIONS
In a separate document, please provide a detailed description of all positive responses (excludes number 1).**

1. If independently licensed, do you have an restricted DEA? Yes [ ]  No [ ]
2. Have you ever had any negative action taken in connection with your license, including, but not limited, to refusal, suspension, revocation, probation reprimand, censure or restriction in any way by any state or jurisdictional board? Yes [ ]  No [ ]
3. Have you ever had your Drug Enforcement Administration number (DEA#) restricted, suspended, revoked or otherwise limited or DEA license application refused?
Yes [ ]  No [ ]  N/A [ ]
4. Have you ever had an agreement with Medicare or Medicaid that was restricted, probational, suspended, excluded or terminated? Yes [ ]  No [ ]
5. Have you ever been required or agreed to pay civil monetary penalties under Medicare or Medicaid? Yes [ ]  No [ ]
6. Have you ever been convicted of a criminal offense other than a minor traffic violation?
Yes [ ]  No [ ]
7. Has any hospital or facility ever taken any action regarding your privileges, including, but not limited, to suspension, restriction, denial or revocation? Yes [ ]  No [ ]
8. Have you ever voluntarily resigned privileges in lieu of disciplinary action? Yes [ ]  No [ ]
9. Has there been, within the last five years, a malpractice judgement found against you or malpractice settlement made, with or without prejudice, in excess of five hundred thousand ($500,000) dollars? Yes [ ]  No [ ]  *Please explain any malpractice judgements in the positive response document for this section.*
10. Do you have an impairment, which even with reasonable accommodation would interfere with your ability to provide care according to accepted standards of professional performance, or would pose a threat to patient health and safety? Yes [ ]  No [ ]
11. Are you now or have you ever been an active habitual user of any mind or mood altering substance, including, but not limited, to alcohol, narcotics, barbiturates, hypnotics, amphetamines, cocaine, benzodiazepines, or other controlled illegal substances? Yes [ ]  No [ ]
12. Has your participation in any insurance carrier sponsored program been suspended or revoked?
Yes [ ]  No [ ]
13. Have you ever left school, internship, residency, or fellowship for any reason other than the expiration of the usual term? Yes [ ]  No [ ]

**REFERENCES**

The letters of recommendation should be written on institution letterhead and mailed directly to the Fellowship Coordinator. Please use the Reference Request Form. Letters should provide the fellowship committee with an assessment of your clinical abilities, academic achievements, leadership potential, communications skills, and an interest in working with rural, low-income, and stigmatized populations. List the names, full addresses, telephone numbers and email addresses of your references below. Current residents and those who have completed their training within the past five years must list their Residency Program Director or Associate Program Director as one of their references.

**Reference 1**

Full Name/Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Institution/Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reference 2**

Full Name/Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Institution/Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reference 3**

Full Name/Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Institution/Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPLICATION SUBMISSION**

Please email this **application form, CV, , and Personal Statement**  to the Fellowship Coordinator, Melissa Cloyd at cloydmc@etsu.edu. **Letters of recommendation** should be written on institution letter head and mailed directly to the Fellowship Coordinator. The PD Checklist for Applicant should be mailed directly to the Fellowship Coordinator. Please use the **Reference Request Form and PD Checklist** **for Applicant** provided on website.

**Melissa Cloyd, Addiction Medicine Fellowship Coordinator**
Department of Family Medicine
Quillen College of Medicine
East Tennessee State University
PO Box 70621
Johnson City, TN, 37614
Tel: 423-439-6396
cloydmc@etsu.edu

**DISCLAIMER AND SIGNATURE**

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release. Typing my name is considered an electronic signature and that I consent to all information submitted to be true.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_