PARKVIEW HEALTH SYSTEM

Insert Current Photo

APPLICATION FOR TRAINING

Type of Training Requested:

(Check one) _______Medical Student __________________from ___________ to___________
(Specialty)

_______ Residency _______________________from ___________to___________
(Specialty)

Applicant Information		
Name:		
Date of birth:	AOA #	AAMC#
Current Home address:		
City: Rockford	State:	ZIP Code:
Permanent Home Address: same as above		
City:	State:	ZIP Code:
Telephone Number:	Email Address:	

Education		
Pre-Medical Education		
Name of School:		
Address: (City and State)	Years Attended: (Month and Year)	
Degree:	Major:	Date:
Name of School:		
Address: (City and State)	Years Attended: (Month and Year)	
Degree	Major:	Date: (Month and Year)
Medical Education		
Name of School:	Years Attended: (Month and Year) 08/2015- present	
Address: (City and State)	Degree: (Earned/Expected)	Graduation Date: (Month and Year)

Exam Scores

COMLEX SCORES	SCORE	ATTEMPS	SCHEDULED	USMLE SCORES	SCORE	ATTEMPTS	SCHEDULED
COMLEX Step 1				USMLE Step 1			
COMLEX Step 2 CK				USMLE Step 2 CK			
COMLEX Step 2 CS				USMLE Step 3			
COMLEX Step 3							

400 W. 16th Street ~ Graduate Medical Education ~ Pueblo, CO 81003 ~ 719-584-4561 ~ F. 719-595-7982

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Applicants Name: ___________________________

Miscellaneous Information						
	Yes	**No**			**Yes**	**No**
BCLS			Exp. Date:	Are you a BCLS or ACLS Certified Instructor?		
ACLS			Exp. Date:	Armed Service Obligation?		
				Public Health Obligation?		
Have you ever been convicted of a felony or misdemeanor other than traffic violations?						
If Yes, please describe:						

To be completed by Residency or Sub-Specialty Applicants Only:

License Information	
Colorado Physician License # (if you have one)	Exp.
DEA # (If you have one)	Exp.

Internship and Residency Training		
Internship at: :		
Street Address:		
City	State:	Zip
Residency at:		
Street Address:		
City	State:	Zip

References (List minimum of three (3) Physicians you will contact for reference letters:	
1.	3.
2.	4.

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Applicants Name: ____________________________

Authorization for Release of Information: TO BE COMPLETED BY ALL APPLICANTS	
By applying for appointment to the house staff (Resident/Intern) of Parkview Health System**,** I authorize the Hospital to consult with members of the medical staffs of other Hospitals with which I have been associated and with others who may have information bearing on my competency, character, and ethical qualifications. I furthermore consent to the Hospital's inspection of all records and documents that may be material to an evaluation of my professional qualifications, competency, and moral and ethical qualifications for house staff appointment. I furthermore release from any liability, all representatives of the Hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials; and release from any liability, all individuals and organizations who provide information to the Hospital in good faith and without malice concerning my competence, ethics, character, and other qualifications for house staff appointment, including otherwise privileged or confidential information. I also release from any liability, all representatives of the Hospital for their acts performed in good faith and without malice in providing information concerning my competence, ethics, character and other qualifications to other institutions where I may apply for training or privileges. I understand that the hospital will be conducting criminal background checks and verification that I am not currently on the Office of Inspector General's excluded provider list. I understand that if I am not on the excluded provider list that any employment offer will be rescinded. In addition, if the background investigation conducted by Parkview Health System reveals information that I have failed to disclose to Parkview Health System as part of the application and/or interview process, I may be subject to immediate discharge or rescission of any offer of employment at this time.	
Signature of applicant:	Date:

RETURN TO: Parkview Health System, Graduate Medical Education, 400 W. 16th St., Pueblo, CO 81003
Email: GraduateMedicalEducation@parkviewmc.com or Fax: 719-595-7982

SUPPLEMENTAL TO TRAINING APPLICATION

Applicants Name: ___________________________________

Please provide a response to the following (Limit 200 words for each)
1. What is it about Parkview Health System's Internal Medicine Residency Program or Gastroenterology Fellowship, Pulmonary Critical Care Fellowship, Cardiology Fellowship or Nephrology Fellowship that makes you want to audition here?
2. Please tell us a fun fact about yourself.

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