Piedmont Heart Institute PA/NP Fellowship(s) in Cardiovascular Critical Care, Surgery, Cardiovascular Disease, and Electrophysiology

Instructions:

- Please submit application and the items listed below to **phiappfellowship@piedmont.org**
- Include:
  - Application completed below, to include your personal statement
  - Passport-sized photo and copy of current CV
  - Official transcripts from your PA/NP program – you may email this, but if asked for interview, please bring official transcripts in a sealed envelope.
  - Three letters of recommendation

Track Preference (please select all that apply):

Cardiovascular Medicine Critical Care	☐	Cardiovascular Surgical Critical Care	☐
Cardiovascular Disease	☐	Cardiovascular Surgery	☐
Electrophysiology	☐		

Applicant Information

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email Address: _____

Date of Birth: _____ Gender: _____

Personal Information:

Are you a US Citizen? Yes or No

If no, are you authorized to work in the US? Yes or No

Have you ever worked for Piedmont Healthcare? Yes or No

If so, when? _____

Have you ever been convicted of a felony? Yes or No

If yes, please provide an explanation:

Education Information:

Graduate Program: _____ Date of Graduation: _____

Degree Received: _____ Dates Attended: _____Through _____

Undergraduate Program: _____ Date of Graduation: _____

Degree Received: _____ Dates Attended: _____Through _____

Letters of Recommendation:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Previous Employment and/or Medical Experience:

Include all employment experiences (post-high school) and account of any gaps in employment.

Company:	Address:
Supervisor:	Phone Number:
Job Title:	Employment Dates:
Company:	Address:
Supervisor:	Phone Number:
Job Title:	Employment Dates:
Company:	Address:
Supervisor:	Phone Number:
Job Title:	Employment Dates:
Company:	Address:
Supervisor:	Phone Number:
Job Title:	Employment Dates:
Company:	Address:
Supervisor:	Phone Number:
Job Title:	Employment Dates:

Have you ever been denied privileges to work in a healthcare setting? Yes or No

If yes, please provide an explanation:

Has your medical license ever been revoked, suspended, or under review? Yes or No

If yes, please provide an explanation:

Military Service:

Branch

Dates of Service:

Rank at Discharge:

Type of Discharge:

If other than honorable, please provide explanation in a separate document.

Disclaimer and Signature:

Authorization & Verification Agreement

I hereby authorize Piedmont Healthcare, the medical staff(s) at Piedmont Healthcare, facilities, and their representatives to consult with administrators and members of the medical staff 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 clinical competence, character and ethical qualifications. I also consent to the inspection by Piedmont Healthcare, the medical staff(s) at Piedmont Healthcare, facilities and its representatives of records and documents that may be material to an evaluation of my qualifications for staff membership. I hereby release from liability any and all individuals and organization who provide, in good faith, information to Piedmont Healthcare, or medical staff(s) at Piedmont Healthcare, and I hereby consent to their release of such information to all personnel involved in the credentialing process at any other facility to which the applicant has applied and which is a part of the Piedmont Healthcare.

I understand that additional information concerning my health may be required for the consideration of this application, and that my health as it relates to my ability to perform my medical staff duties appropriately will be an ongoing consideration. I agree that my activities as a member of the medical staff will be bound by the provisions of the Institutional Bylaws, Rules and Regulations, and Code of Conduct. I understand that any significant misstatement in or omission from this application will constitute cause for immediate denial of Appointment or summary dismissal from this Program.

I consent to the release of information provided in this application to any insurance plan in which Piedmont Healthcare, or a component Piedmont Healthcare, is a participating entity, subject to Piedmont Healthcare, receiving from the plan an authorization for the release of such information, which I have executed. I hereby declare that the statements in this application and all attachments hereto are complete and accurate.

Applicant Signature: Date: