



Continuum Health Partners, Inc.

Resident/Fellow Processing Form

Academic Year ____ - ____

General Personal Information

Last Name	First Name	Middle Name	Social Security No.
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I Am Entering The Following Graduate Program:

Appointment Start Date:	NRMP Participant <input type="checkbox"/> Yes <input type="checkbox"/> No	Citizenship: <input type="checkbox"/> US Other _____
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Applying As: Fellow in an Pain Medicine Program: Medical Modality Interventional
 Fellow in a Hospice & Palliative Medicine (Non-Accredited Program)

Have you participated in a rotation at Beth Israel Medical Center in the past? Yes No

Visa Status (If Not a US Citizen) **PLEASE ATTACH COPY OF PROOF OF VISA STATUS**

J-1 J-2 H-1B Temporary Specify _____ Permanent Alien Registration # _____

Expiration Of Status: (Date): _____ Permanent Validation of ECFMG

Former/Maiden Name (If Applicable)	Date Of Birth / /	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	City/Country Of Birth	Ethnicity
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Home Address / Street	Apt. #	City	State	Zip	Home Phone
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Preferred Mailing Address / Street	Apt. #	City	State	Zip	Preferred Phone:
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E-Mail Address:	Beeper:	Fax Number:
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In Case Of Emergency Contact Name:	Relationship:	Phone Number (Area Code) (H) () (W) ()
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Address: Street Address, City, State, Zip Code, Country	Languages Spoken
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Education and Training *(ERAS application acceptable- Please attach to this form)

*Undergraduate Education

Institution Name			
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Street	City	State/Country	Zip/Country Code
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Degree	Graduation Date (Date Degree was Conferred) (Mo./Yr.)	Dates Attended: From (Mo./Yr.) To: (Mo./Yr.)
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*Medical School

Institution Name			
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Street	City	State/Country	Zip/Country Code
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Degree	Graduation Date (Date Degree was Conferred) (Mo./Day/Yr.)	Dates Attended From: (Mo./Yr.) To: (Mo./Yr.)
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*Graduate Education			
Institution Name			
Street	City	State/Country	Zip
Dates Attended (Mo./Yr)	From	To	
Program			
Did You Successfully Complete This Program? <input type="checkbox"/> Yes <input type="checkbox"/> No Degree Conferred :			
*Internship			
Institution Name			
Street	City	State/Country	Zip
Program Name/Specialty	Dates Attended: From: (Mo./Yr.) To: (Mo./Yr.)		
Did You Successfully Complete This Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	ACGME / ADA Approved? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*First Residency Training			
Institution Name			
Street	City	State/Country	Zip
Program Name/Specialty	Dates Attended From: (Mo./Yr.) To: (Mo./Yr.)		
Did You Successfully Complete This Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	ACGME / ADA Approved? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*Second Residency (If Additional Residencies, Please Attach a Separate Sheet)			
Institution Name			
Street	City	State/Country	Zip
Program Name/Specialty	Dates Attended From: (Mo./Yr.) To: (Mo./Yr.)		
Did You Successfully Complete This Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	ACGME / ADA Approved? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*Fellowship/Training			
Institution Name			
Street	City	State/Country	Zip
Fellowship Program Name/SubSpecialty	Dates Attended From: (Mo./Yr.) To: (Mo./Yr.)		
Did You Successfully Complete This Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	ACGME / ADA Approved? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*Second Fellowship (If Additional Fellowships, Please Attach a Separate Sheet)			
Institution Name			
Street	City	State/Country	Zip
Fellowship Program Name/Sub-Specialty	Dates Attended From: (Mo./Yr.) To: (Mo./Yr.)		
Did You Successfully Complete This Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	ACGME / ADA Approved? <input type="checkbox"/> Yes <input type="checkbox"/> No		



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Research Experience:

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Awards Received:

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Examinations/Licensure

Applied To Take: USMLE Step I USMLE Step II USMLE Step III

Already Passed:
USMLE Step I USMLE Step II USMLE Step III NBME, Part I NBME, Part II NBME, Part III

ECFMG # (Or Fifth Pathway Issue Date: _____ ECFMG Certificate Valid Indefinitely: Yes No
If "No", Expiration Date: _____

TOFL Exam: (expiration date) _____ Clinical Skills Exam: (expiration date) _____

BLS Certified: Yes No Expires: _____ ACLS Certified: Yes No Expires: _____ PALS Certified: Yes No Expires: _____

License: **New York State?** Yes No License Number _____ Expiration Date _____ Permanent Limited Temporary

Do You Have A License In Any Other State Or Country? Yes No If Yes, please list state(s): _____

License Number : _____ Date of Issue _____ Expiration Date _____ Permanent Limited Temporary

Medicare/UPIN (Unique Provider Id Number) _____ Medicaid Number _____

Federal DEA Number _____ Expiration Date _____ Is DEA Number Restricted? Yes No
(If Yes, Explain On Attached Page)

State DEA/CDS (If Applicable) _____ Expiration Date _____ Is DEA/CDS Number Restricted? Yes No
(If Yes, Explain On Attached Page)

Professional References

Please List at least 3 Professional References. One must be Dean's Letter from Degree Granting Institution and two from Physicians who most recently supervised your clinical work.

1. Name _____ Telephone _____

Street Address _____

City _____ State _____ Zip _____

2. Name _____ Telephone _____

Street Address _____

City _____ State _____ Zip _____

3. Name _____ Telephone _____

Street Address _____

City _____ State _____ Zip _____

4. Name _____ Telephone _____

Street Address _____

City _____ State _____ Zip _____



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Service Obligations (National Health Service Corps, Armed Forces Scholarship, State Programs, Etc.)

- I Am Not Required To Fulfill Any Service Obligations
- I Am Committed To Fulfill A Service Obligation Beginning (Mo./Yr.) _____

Training and Employment Interruptions (including resignations and terminations)

- Have there been any interruptions in your training? Yes No If yes, explain (attach separate sheet)
- Have you ever resigned (or been forced to resign), or been terminated from a training program? Yes No
If yes, explain (attach separate sheet)
- Have you ever resigned (or been forced to resign), or been terminated from any employment? Yes No
If yes, explain (attach separate sheet)

CONSENT and RELEASE signed and attached (page 5) Yes
(This form will not be processed without a signed consent and release form.)

Are any required additional pages (explanations, etc.) included? Yes
(This form will not be processed unless fully complete, including all attachments.)

I affirm under the penalty of perjury, that all information submitted by me in this processing form is true and accurate. I understand that any significant misstatements and/or omissions from the processing form may be cause for dismissal or denial of appointment.

Signature and Academic Degree

Date

Name (Please print)

Optional Information: (For statistical reporting as requested by State and Federal Government agencies.)

- Marital Status:
- Single Married Separated Divorced Legally Separated
- Military reporting Status:
- Vietnam Veteran Vietnam Veteran with Disability Non Vietnam Veteran



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CONSENT AND RELEASE AUTHORIZATION FORM

By submitting this processing form to become a member of the BIMC House Staff (either as a full time trainee or rotator), I hereby:

- Authorize representatives of Beth Israel Medical Center to consult with representatives of other health care related facilities...
Consent to the inspection by representatives of Beth Israel Medical Center of all records and documents...
Release from any liability all representatives of Beth Israel Medical Center including their medical staff(s) and allied health professional staff(s)...
Release from any liability all individuals and organizations who provide information to representatives of Beth Israel Medical Center...
Authorize representatives of Beth Israel Medical Center including their medical staff(s) and allied health professional staff(s) to provide to health care facilities...
Affirm that all information submitted by me in this processing form is true to the best of my knowledge and belief...

THIS FORM WILL NOT BE PROCESSED UNLESS ALL REQUESTED INFORMATION HAS BEEN SUPPLIED.

(Signature)

(Date)

Name (please print)