LSU Health SHREVEPORT

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT & AFFILIATED HOSPITALS
1501 Kings Highway •P.O. Box 33932•Shreveport, LA 71130-3932
Telephone: (318) 675-5053 / Fax: (318) 675-5069

ATTACH ONE (1) ORIGINAL PHOTOGRAPH

APPLICATION FOR RESIDENCY/FELLOWSHIP PROGRAM

START DATE:	MARK APPROPRIATE LEVEL: ☐PGY I ☐PGY II ☐PGY III ☐PGY IV ☐PGY V ☐PGY VI ☐PGY VI ☐PGY VII

TRAINING PROGRAM:

- ☐ Anesthesiology
- ☐ Emergency Medicine
- ☐ EM/FM
- ☐ Family Medicine – Alexandria
- ☐ Family Medicine – Shreveport
- ☐ Family Medicine – Monroe
- ☐ Family Medicine – North Caddo
- ☐ Internal Medicine - Prelim
- ☐ Internal Medicine
- ☐ Medicine/Pediatrics
- ☐ Neurology
- ☐ Neurosurgery
- ☐ Obstetrics & Gynecology
- ☐ Ophthalmology
- ☐ Oral Surgery
- ☐ Orthopaedic Surgery
- ☐ Otolaryngology
- ☐ Pathology
- ☐ Pediatrics
- ☐ Psychiatry
- ☐ Radiology
- ☐ Surgery – Prelim
- ☐ Surgery
- ☐ Urology

FELLOWSHIP:

- ☐ Pain Management
- ☐ Cardiology
- ☐ Interventional Cardiology
- ☐ Critical Care Medicine
- ☐ Endocrinology
- ☐ Gastroenterology
- ☐ Hematology/Oncology
- ☐ Sleep Medicine
- ☐ Infectious Diseases
- ☐ Nephrology
- ☐ Pulmonary/Critical Care
- ☐ Rheumatology
- ☐ Cytopathology
- ☐ Allergy/Immunology
- ☐ Child & Adolescent Psychiatry
- ☐ Forensic Psychiatry
- ☐ Colon&Rectal Surgery
- ☐ Oral Surgery
- ☐ Other

DEMOGRAPHIC INFORMATION

LEGAL LAST NAME	LEGAL FIRST NAME	MIDDLE INITIAL	TITLE (MD, DO, DDS, ETC.)

DATE OF BIRTH	PLACE OF BIRTH	**US** SOCIAL SECURITY NUMBER	GENDER: ☐Male ☐Female

MAILING ADDRESS	CITY	STATE	ZIP	CELL/HOME PHONE

EMERGENCY CONTACT	RELATIONSHIP	CONTACT PHONE

EMERGENCY CONTACT MAILING ADDRESS	CITY	STATE	ZIP

MARITAL STATUS ☐Single ☐Married ☐Divorced ☐ Widowed	IF MARRIED, SPOUSE'S NAME	PERSONAL EMAIL (not school issued email)

ARE YOU A U.S. CITIZEN?
☐Yes
☐No ➡ Country of citizenship:

ARE YOU A PERMANENT RESIDENT?
☐Yes
☐No ➡ ☐J-1 Visa Sponsorship Needed ☐ EAD
☐ Other _____
*LSUHSC Shreveport does **not** sponsor H-1Bs for training purposes.

PLEASE INDICATE ONE: ☐US Graduate ☐Non US Foreign Medical School Graduate	ECFMG# (If Applicable)	DATE ISSUED

National Provider Identifier (NPI#) (If Applicable)

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Please answer the following questions. Any "YES" response will require an explanation on a separate sheet.	YES	NO
1. Have you ever been charged with, and/or convicted of, pled guilty or nolo contendere to, any violation of any municipal, county/parish, state or federal statute; are any charges pending against you at this time? (Should not include minor traffic citations.)	☐	☐
2. Have you ever been denied a professional license, resident permit, or certification by any licensing or certifying board or agency and/or are there any actions, proceedings or investigations, past or pending, related to your license, permit or certification?	☐	☐
3. Have you ever failed a licensure/certification examination? (USMLE, COMLEX, TOEFL, etc.) If yes, how many times ( )	☐	☐
4. Have you ever been denied membership in a state, county, or local professional society? Has your membership in a state, county, or local professional society ever been revoked, suspended, placed on probation, or restricted in any manner?	☐	☐
5. Have you ever been denied, had suspended, revoked or restricted, or voluntarily relinquished staff or clinical privileges in any hospital or health care institution or organization?	☐	☐
6. Have you had any malpractice claims filed against you within the last five (5) years?	☐	☐
7. Do you have a federal or state controlled substance permit? If yes, provide copies.	☐	☐
8. Have you ever voluntarily surrendered, or did you have suspended, revoked or restricted, your narcotics controlled substances license or registration (state or federal)?	☐	☐
9. Have you ever voluntarily surrendered, or did you have suspended, revoked, placed on probation, or restricted in any manner, any professional license issued by any licensing authority?	☐	☐
10. Have you ever been the subject of any type of disciplinary action or inquiry including fraud by any licensing agency, hospital, institution, society, etc.?	☐	☐
11. Have you ever received notice of termination or been sanctioned, monitored (excluding random monitoring), or excluded from status as a supplier of services under the Medicare, Medicaid, CLIA, Champus or any other Federal or State government programs?	☐	☐
12. Have you ever been subject to any type of disciplinary action, terminated or dismissed from any previous training program?	☐	☐
13. Have you ever agreed to not seek re-licensure in any licensing jurisdiction?	☐	☐
14. Have you ever initiated a proceeding, suit, or action against another provider or institution?	☐	☐

In making this application, I fully understand that it is my duty to promptly report any changes in the response(s) to the questions resulting during my practice in this Institution, or any other setting or institution, and that failure to do so shall constitute cause for summary suspension and dismissal from the training program. I do hereby also specifically authorize the hospital and release it, its representatives, and all organizations and individuals who provide information to the hospital from liability in their obtaining information regarding any changes or potential changes in my response to these questions. I hereby waive all rights I may have against any person, institution, or organization conveying such information or releasing such information to LSU Health Shreveport.

APPLICANT SIGNATURE	**DATE**