



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: <input type="checkbox"/> PGY I <input type="checkbox"/> PGY II <input type="checkbox"/> PGY III <input type="checkbox"/> PGY IV <input type="checkbox"/> PGY V <input type="checkbox"/> PGY VI <input type="checkbox"/> PGY VI <input type="checkbox"/> PGY VII
TRAINING PROGRAM:	
<input type="checkbox"/> Anesthesiology <input type="checkbox"/> Emergency Medicine <input type="checkbox"/> EM/FM <input type="checkbox"/> Family Medicine – Alexandria <input type="checkbox"/> Family Medicine – Shreveport <input type="checkbox"/> Family Medicine – Monroe <input type="checkbox"/> Family Medicine – North Caddo <input type="checkbox"/> Internal Medicine - Prelim <input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Medicine/Pediatrics <input type="checkbox"/> Neurology <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Obstetrics & Gynecology <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Orthopaedic Surgery <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Pathology
<input type="checkbox"/> Pediatrics <input type="checkbox"/> Psychiatry <input type="checkbox"/> Radiology <input type="checkbox"/> Surgery – Prelim <input type="checkbox"/> Surgery <input type="checkbox"/> Urology	FELLOWSHIP: <input type="checkbox"/> Pain Management <input type="checkbox"/> Cardiology <input type="checkbox"/> Interventional Cardiology <input type="checkbox"/> Critical Care Medicine <input type="checkbox"/> Endocrinology <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Hematology/Oncology <input type="checkbox"/> Sleep Medicine
<input type="checkbox"/> Infectious Diseases <input type="checkbox"/> Nephrology <input type="checkbox"/> Pulmonary/Critical Care <input type="checkbox"/> Rheumatology <input type="checkbox"/> Cytopathology <input type="checkbox"/> Allergy/Immunology <input type="checkbox"/> Child & Adolescent Psychiatry <input type="checkbox"/> Forensic Psychiatry <input type="checkbox"/> Colon&Rectal Surgery	<input type="checkbox"/> Oral Surgery <input type="checkbox"/> 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: <input type="checkbox"/> Male <input type="checkbox"/> Female
MAILING ADDRESS		CITY	STATE	ZIP	CELL/HOME PHONE
EMERGENCY CONTACT		RELATIONSHIP	CONTACT PHONE		
EMERGENCY CONTACT MAILING ADDRESS		CITY	STATE	ZIP	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		IF MARRIED, SPOUSE'S NAME	PERSONAL EMAIL (not school issued email)		
ARE YOU A U.S. CITIZEN? <input type="checkbox"/> Yes <input type="checkbox"/> No → Country of citizenship:			ARE YOU A PERMANENT RESIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No → <input type="checkbox"/> J-1 Visa Sponsorship Needed <input type="checkbox"/> EAD <input type="checkbox"/> Other _____		
PLEASE INDICATE ONE: <input type="checkbox"/> US Graduate <input type="checkbox"/> 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.)	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever failed a licensure/certification examination? (USMLE, COMLEX, TOEFL, etc.) If yes, how many times ()	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any malpractice claims filed against you within the last five (5) years?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have a federal or state controlled substance permit? If yes, provide copies.	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever voluntarily surrendered, or did you have suspended, revoked or restricted, your narcotics controlled substances license or registration (state or federal)?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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.?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever been subject to any type of disciplinary action, terminated or dismissed from any previous training program?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever agreed to not seek re-licensure in any licensing jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever initiated a proceeding, suit, or action against another provider or institution?	<input type="checkbox"/>	<input type="checkbox"/>
<p>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.</p>		
<p>APPLICANT SIGNATURE</p>	<p>DATE</p>	