Instruction for Completion

Instruction for Completion of Application for Appointment to Graduate Medical Education at University of North Carolina Hospitals Chapel Hill, North Carolina 27514

In addition to completing the online GME Application, all applicants must submit the following documents directly to the Training Program to which you (hereinafter the "Applicant") are applying:

Applicants applying for 1st Year Post Graduate Positions;
1. Three letters of reference.

a. (1) Medical Student Performance Evaluation (MSPE) from the medical school where the Applicant graduated, or if an MSPE is not available, a Dean's (or Dean's designee) letter of reference from the medical, dental or graduate school from which the Applicant graduated, and;

b. Two (2) letters of reference from members of the medical or dental staff of the hospital affiliated with the medical or dental school from which the Applicant graduated, or from physicians (for medical residencies), dentists (for dental residencies), or academic instructors (for non-physician McLendon Labs residencies) with current knowledge of the Applicant's experience, ability, educational accomplishments and character (which may include, but is not required to include, the Chairman of the chosen specialty or their designee).

2. An official, final Medical/Dental/Graduate School transcript from the Registrar of the Medical/Dental/Graduate school.

Applicants with previous training and those applying for above 1st-Year Post Graduate Positions, including applicants who are changing specialties:
1. Three letters of reference.
a. One (1) letter of reference from the Program Director of the residency/fellowship program in which the Applicant has most recently served; and

b. Two (2) letters of reference from members of the medical or dental staff of the hospital affiliated with the residency/fellowship program from which the Applicant has most recently served, or from physicians (for medical residencies), dentists (for dental residencies), or academic instructors (for non-physician McLendon Labs residencies) with current knowledge of the Applicant's experience, ability, educational accomplishments and character (which may include, but is not required to include, the Chairman of the chosen specialty or their designee).

2. An official, final Medical/Dental/Graduate School transcript from the Registrar of the Medical/Dental/Graduate School.

The responsibility for securing letters of reference rests with the Applicant. *All letters of recommendation should be addressed directly to the Chief of Service or Director of the Training Program in which the Applicant is interested.* DO NOT have recommendation letters sent directly to the Director of Graduate Medical Education or just to UNC Hospitals.

Instruction for Completion | **Personal Information** | Education | Chronological Training History | Work Eligibility | Acknowledgement & Waiver | Attestation

Biographic/Demographic Information

First Name: * John

Middle Name: Quincy

Last Name: * Public

Suffix:

Do you have a NPI Number?: * (s

Previous Legal Name:

Are you legally authorized to work in the U.S.?: * (s

Do you require a work visa to be legally authorized to work in the U.S.?: * (s

Program Information

Anticipated Residency/Fellowship Program: * (s

Anticipated Start Date: *

Position Applying for: * (s

Stipend levels for trainees entering programs beyond their first core residency training program will be determined on the basis of the number of accredited years required by the ACGME for eligibility in that program regardless of any other advanced or GME training the trainee may have completed.

Did you match into this program?: * (s

Contact Information

Contact Email Address: *

Contact Phone: * (Home)

Contact Phone: * (Cell)

Street address: * (line 1)

Street Address: (line 2)

Country: * U

City: *

State: * (s

Zip code: *

Emergency Contact

Contact Name (First & Last): *

Relationship: *

Primary Phone #: * (Home)

Primary Phone #: * (Cell)

Street Address: *

City: *

State: *

(select one)

Zip code: *

Country: *

United States

Licensure

Do you have a current Medical License?: *

Yes

License Type: *

(s

License #: *

State: *

(s

Expiration date: *

Military/Veteran Status

Have you ever served in the US Armed Forces?: *

(s

Medical/Dental School

☐ Non-Medical Resident. No Medical/Dental School.

School Name:
(s

Degree Awarded/Anticipated:
M

Dates of Attendance: * (start date)

Date of Attendance: * (end date/anticipated end date)

Are you an Alpha Omega Alpha Member?:
(s

Are you certified by the ECFMG?: *
(s

Graduate School or Other Professional Education

☐ I do not have Professional Education or a Graduate School record.

School Name: *

Degree Awarded/Anticipated: *
(s

Dates of Attendance: * (start date)

Dates of Attendance: * (end date/anticipated end date)

Undergraduate School

☐ I did not attend an Undergraduate School

School Name: *

Degree Awarded: *

(s

Start Date: *

Date Awarded/Conferred: *

Current and Prior Training

List in chronological order EVERYTHING beginning after Medical School graduation. This would include places of employment, hospitals, teaching institutions, private practice, corporations, military assignments, government agencies, vacations, times off, and locum tenens assignments. THE GME Office requires you account for any and all time. NO time gaps will be accepted. You will need to label any unemployment time as "vacation", "relocation, or "research" (whatever is appropriate). Provide details regarding these gaps in the comments section. A CV will not replace completing this section of the application.

☐ Recent Medical School graduate. No training history

Records already entered in MedHub

If you see inconsistencies with your existing training history record as noted below, please contact the GME Office.

Type of History: *	Program Name: *	Start Date: *	End date: *
(no data)	*(no data)*	*(no data)*	*(no data)*

Records entered by Trainee

Type of History: *
(s

Comments or Description of activities/duties: * (50 characters left)

Training Institution/Hospital/Facility/Practice: *

Program Name: *
(s

Start Date: *

End date: *

Address: *

City: *

State: *
(s

Country: *
U

Zip code: *

Name of Program Director/ Supervisor: *

Did you complete this program: *
(select

Liability/Disciplinary Actions

If you answer "yes" to any of the questions below, please provide an explanation.

1. Have you ever pled guilty, been found guilty by judge or jury, or pled no contest to a violation of federal, state, or local law, other than a minor traffic violation? (Do not disclose information that has been expunged from your record.) * ◯ Yes ◯ No
2. Have you ever been charged with driving under the influence or while impaired? * ◯ Yes ◯ No
3. Have you ever been voluntarily or involuntarily placed on probation, suspended or terminated from a Residency Program or Medical or Dental Staff? * ◯ Yes ◯ No
4. Was your Medical, Dental or Graduate School training interrupted for any reason? * ◯ Yes ◯ No
5. Are you now, or have you ever been, involved in any litigation, lawsuits, claims or arbitration related to your professional activities? * ◯ Yes ◯ No
6. Have judgments or settlements been made against you in professional liability cases or are you involved in any pending litigation involving professional liability? * ◯ Yes ◯ No
7. Have you ever been denied liability insurance? * ◯ Yes ◯ No
8. Has your membership or renewal thereof in any medical, dental or professional organization ever been revoked, suspended, diminished or denied? * ◯ Yes ◯ No
9. Have your privileges in any hospital ever been suspended, diminished, revoked or not renewed? * ◯ Yes ◯ No

Ability to Perform Duties

Are you able to carry out the responsibilities of a resident or a fellow in the specific training program to which you are applying, including the functional requirements, cognitive requirements, and interpersonal and communication requirements with or without reasonable accommodations?: *

- ◯ Yes
- ◯ No

Acknowledgment and Waiver

Please notify the training program immediately if any of your responses on this application change.

ACKNOWLEDGEMENT AND WAIVER

By applying to a residency/fellowship program at the University of North Carolina Hospitals, I hereby confirm that I am willing to appear in person for interviews in connection with my application.

I understand that in connection with my application, I am required to review and sign a separate Authorization to Obtain Consumer Report, which allows UNC Hospitals' Office of Graduate Medical Education to utilize a Consumer Reporting Agency (CRA) to prepare a consumer report or investigative consumer report about me.

I authorize my current and former employers, any law enforcement agency, administrator, local, state or federal agency, institution, school or university, information service bureau, insurance company, or other persons or agencies having knowledge about me to provide any and all requested information to the University of North Carolina Hospitals Office Of Graduate Medical Education. I understand that this authorization shall remain in effect for the duration of my employment with UNC Hospitals.

I hereby release from liability all representatives of the University of North Carolina Health Care System, University of North Carolina Hospitals and the University of North Carolina at Chapel Hill's Schools of Medicine/Dentistry for their acts performed in good faith in evaluating my application, my credentials, my consumer report, and my qualifications. I also hereby release from liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to the University of North Carolina Health Care System, University of North Carolina Hospitals and the University of North Carolina at Chapel Hill's Schools of Medicine/Dentistry in good faith and without malice concerning my professional status or other qualifications.

I certify that all statements on this application are true and complete to the best of my knowledge. I understand that any misstatements, omissions, or falsification in any document related to this application may result in rejection of my application or my dismissal if I am employed. I understand that if I become employed by the University of North Carolina Health Care System, University of North Carolina Hospitals or the University of North Carolina at Chapel Hill's Schools of Medicine/Dentistry, I will be required to produce original documents verifying (1) my identity, and (2) my authorization to work in the United States, in compliance with the Federal Immigration Reform and Control Act of 1986.

I understand that if I am accepted into the Graduate Medical Education program at University of North Carolina Hospitals, it is mandatory that I immediately provide my Social Security Number to the Office of Graduate Medical Education because the University of North Carolina Health Care System, University of North Carolina Hospitals, and/or the University of North Carolina at Chapel Hill's Schools of Medicine/Dentistry must disclose my Social Security Number pursuant to various federal and state laws involving taxes, income, and debt owed to the state. Accordingly, upon my admission to University of North Carolina Hospitals' Graduate Medical Education program, I will immediately provide my Social Security Number to the Office of Graduate Medical Education.

I understand that any offer of employment as a resident or fellow at the University of North Carolina Health Care System, University of North Carolina Hospitals, and/or the University of North Carolina at Chapel Hill's Schools of Medicine/Dentistry is contingent upon my passing a pre-employment substance abuse screening and background check, including verification of prior education, employment, and criminal background.

Type Name **(John Q. Public)**: *

Date: *
2/6/2023

Authorization to Obtain Consumer Report

DISCLOSURE STATEMENT

In connection with your application for appointment to Graduate Medical Education at University of North Carolina Hospitals, University of North Carolina Hospitals' Office of Graduate Medical Education and/or The University of North Carolina Health Care System (collectively, "UNC Health") may utilize a Consumer Reporting Agency (CRA) to prepare a consumer report or investigative consumer report, which may include information concerning your character, employment history, general reputation, personal characteristics, police record, criminal records, education, qualifications, motor vehicle record, professional credentials, mode of living and/or credit and indebtedness.

AUTHORIZATION

I have read and understand the foregoing Disclosure Statement, and authorize UNC Health to obtain and rely upon consumer reports or investigative consumer reports from a CRA for purposes of making decisions regarding my employment. I authorize my current and former employers, any law enforcement agency, administrator, local, state or federal agency, institution, school or university, information service bureau, insurance company, or other persons or agencies having knowledge about me to provide any and all background information requested by a CRA on behalf of UNC Health for purposes of preparing a consumer report or investigative consumer report. I understand that this authorization shall remain in effect for the duration of my appointment to and/or employment with UNC Health.

By my signature below, I authorize UNC Health to obtain consumer reports or investigative consumer reports from a CRA and to share the information received with any person involved in making decisions about my appointment or employment.

Type Name **(John Q. Public)**: *

Date: *
2/6/2023