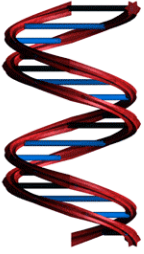


UCLA Intercampus Medical Genetics Training Program

APPLICATION FORM



Attach
Photograph Here
(Optional)

Please Check One:

Track A

Clinical

Track B

Research

Track C

Combined

Clinical/research

PLEASE NOTE: APPLICATIONS WILL NOT BE CONSIDERED FOR REVIEW UNTIL ALL LETTERS OF RECOMMENDATION HAVE BEEN RECEIVED.

Today's Date:

Genetic Specialty Area(s) In Which You Are Interested:

Clinical Genetics

Medical Biochemical Genetics

Clinical Biochemical Genetics

Clinical Molecular Genetics

Cytogenetics

Other:

Name In Full:

Degree(s):

Address: (Home):

Address (Work):

Telephone: Work:

Home:

E-mail Address: _

Cell Phone:

Citizenship:

Visa Status:

Birthplace (optional):

Birthdate (optional):

Date Available to Start:

Foreign Medical Graduates Only:

ECFMG #:

(Please enclose a copy of your ECFMG certificate or interim letter. We also need a copy of your review letter from the California Medical Board if you are interested in Clinical Medical Genetics.)

Name:

Training:

Postdoctoral Experience:
Institution

Area of Training

Dates Trained
(m/yy-m/yy)

Internship:

Institution

Area of Training

Dates Trained

-

-

Residency:

Institution

Area of Training

Dates Trained

Other Professional Experience:

Education:

Name of University

Dates
Attended

Degree
Earned (MD, PhD)

Major

U.S. States in Which Licensed:

License #(s):

Specialty Board Exam(s):

USMLE Exam Date(s):

Name:

Have you ever been supported by a NIH training grant?

Yes No

If yes, was it

Predoctoral Or Postdoctoral.

If yes, please list Grant Number(s) and dates of support:

Research Experience:

Published Papers: Y N (If Yes, Attach Bibliography)

Professional Societies you belong to:

Please have 3 individuals currently involved with your training or work, and who know you professionally, forward a letter of recommendation directly to Dr. David Rimoin. These will be kept on file with your application.

David Rimoin, MD, PhD

Program Director

UCLA Intercampus Medical Genetics Training Program

Cedars-Sinai Medical Center

8700 Beverly Blvd. #665-W

Los Angeles, CA 90048

Name, Title, And Phone Number of your 3 References:

1. Phone:

2. Phone:

3. Phone:

How Did You Learn About Our Program?

Program Flyer Faculty Advisory ACGME Web Site RRC Guide

Journal Ad, Please Specify Journal:

Other, Please Explain:

Name:

Please summarize your interests in medical genetics, what you hope to achieve from your training program, and why you think our program is the right one for you.

Please return this form by fax or e-mail to Patricia Kearney fax: 310-423-1869 or e-mail: patricia.kearney@cshs.org
Thank you.

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical schools, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this application regarding my professional training, education, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect application information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in training at this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, non-renewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (v) my conviction of any crime (excluding minor traffic violations); or (vi) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application, employment or physician participation agreement. A photocopy of this document shall be as effective as the original, however, original signatures and current dates are required on this page.

Print Name Here:

Name Printed: _____

Physician Signature _____ Date: _____
(Stamped Signature Is Not Acceptable)