

**MERCER UNIVERSITY SCHOOL OF MEDICINE  
DEPARTMENT OF COMMUNITY MEDICINE  
VOLUNTEER FACULTY APPOINTMENT APPLICATION**

**\*\*\*\*In addition to this application, please enclose proof of Malpractice Insurance Coverage (copy of certificate of insurance showing company, policy number, amount of coverage of at least \$1,000,000, parties covered under terms of policy).\*\*\*\***

**NAME** (Please type or print) \_\_\_\_\_ **DATE** \_\_\_\_\_

\_\_\_\_\_

Last

First

Middle

**DATE OF BIRTH** \_\_\_\_\_ **GENDER** \_\_\_\_\_

Month      Day      Year

**HOME TELEPHONE** (\_\_\_\_) \_\_\_\_\_

**HOME ADDRESS** \_\_\_\_\_

\_\_\_\_\_

Street

City

County

State

Zip

**CORP/ASSOC. NAME** \_\_\_\_\_

**PHYSICAL ADDRESS** \_\_\_\_\_

\_\_\_\_\_

Street

City

County

State

Zip

**MAILING ADDRESS** \_\_\_\_\_

\_\_\_\_\_

Street/PO

City

County

State

Zip

**IS THERE AN OFFICE E-MAIL ADDRESS USED FOR COMMUNICATIONS? \_\_\_\_\_ DO YOU WISH TO RECEIVE COMMUNICATIONS BY E-MAIL? \_\_\_\_\_**

**E-MAIL ADDRESS** \_\_\_\_\_

**BUSINESS TELEPHONE** (\_\_\_\_) \_\_\_\_\_ **FAX NUMBER** (\_\_\_\_) \_\_\_\_\_

**OFFICE CONTACT AND TITLE** \_\_\_\_\_

**EDUCATION**

**UNDERGRADUATE** \_\_\_\_\_

College or University      Degree      Date

**HIGHEST GRADUATE DEGREE** \_\_\_\_\_

College or University      Degree      Date

**INTERNSHIP**

Type	Date Completed
Institution	City
	State

**RESIDENCY**

Type	Date Completed
Institution	City
	State

**OTHER POSTGRADUATE WORK**

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**FELLOWSHIPS**

**BOARD CERTIFIED** \_\_\_\_\_ YES \_\_\_\_\_ NO      Specialty \_\_\_\_\_      Year \_\_\_\_\_

**OTHER CERTIFICATION**

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**PRACTICE HISTORY**

State	Location	Type of Practice

**LICENSURES**

State	Number	State	Number

**HAS YOUR LICENSE EVER BEEN REVOKED, SUSPENDED OR RESTRICTED?**    \_\_\_ YES    \_\_\_ NO

If yes, please explain

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**DO YOU HAVE A CURRENT DEA NUMBER?**                    \_\_\_\_\_ YES                    \_\_\_\_\_ NO

**DO YOU HAVE ANY PENDING OR RESOLVED MALPRACTICE LITIGATIONS IN WHICH YOU ARE OR HAVE BEEN INVOLVED?**                    \_\_\_\_\_ YES                    \_\_\_\_\_ NO

If yes, please explain and indicate if resolved or pending. *(Attach additional information as needed)*

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**HOSPITAL AFFILIATIONS**

**NAME(S):** \_\_\_\_\_  
**LOCATION(S):** \_\_\_\_\_

**NAME:** \_\_\_\_\_  
**LOCATION(S):** \_\_\_\_\_  
\_\_\_\_\_

Do you make rounds at the hospital and will the student accompany you? \_\_\_\_\_

Are you a member of a hospital board? \_\_\_\_\_

Do you attend hospital staff meetings? \_\_\_\_\_

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**OFFICE DEMOGRAPHICS**

**TYPE OF PRACTICE (GROUP, SOLO) ETC.** \_\_\_\_\_

**OTHER PROVIDERS (MD,PA, NP)** \_\_\_\_\_

**ESTIMATE THE AVERAGE # OF PATIENTS YOU SEE WEEKLY** \_\_\_\_\_

**ESTIMATE THE AVERAGE # OF PATIENTS SEEN BY PRACTICE** \_\_\_\_\_

**ESTIMATE THE AVERAGE # OF HOSPITALIZED PATIENTS PER WEEK**  
\_\_\_\_\_

**NUMBER & TYPES OF SURGERY PERFORMED IN HOSPITAL PER MONTH** \_\_\_\_\_

**AVERAGE NUMBER OF DELIVERIES PER MONTH** \_\_\_\_\_

**MEDICAL FACILITIES UTILIZED (Check all that apply)**

- a. **Mental Health Facility** \_\_\_\_\_
- b. **Home Health Care** \_\_\_\_\_
- c. **Nursing Home** \_\_\_\_\_
- d. **Ambulatory Surgery Center** \_\_\_\_\_
- e. **Emergency Clinic** \_\_\_\_\_
- f. **Health Department** \_\_\_\_\_
- g. **Jail** \_\_\_\_\_

**REFERENCES:** (Name and Contact, Mailing Address, Telephone Number, Fax Number)

(1) \_\_\_\_\_  
\_\_\_\_\_

(2) \_\_\_\_\_  
\_\_\_\_\_

(3) \_\_\_\_\_  
\_\_\_\_\_

**IS THERE FREE OR LOW COST HOUSING AVAILABLE FOR STUDENTS?** \_\_\_\_\_

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Signature