



Academic Affairs

APPLICATION FOR OFF-CYCLE RECRUITMENT			
First Name	Last Name	MD/DO	Date
Street	City	State	Zip Code
Phone Number	Email Address		

Applying to:
Residency Program
<input type="checkbox"/> Dermatology <input type="checkbox"/> Family Medicine <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Physical Medicine & Rehab <input type="checkbox"/> Surgery
Fellowship Program
<input type="checkbox"/> Addiction Medicine <input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> Clinical Informatics <input type="checkbox"/> Electrophysiology <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Geriatric Medicine <input type="checkbox"/> Hospice and Palliative Medicine <input type="checkbox"/> Interventional Cardiology <input type="checkbox"/> Surgical Critical Care <input type="checkbox"/> Vascular Surgery

Do you require sponsorship of a visa? <small>***Please discontinue the application process if you require sponsorship of a visa. Currently, HonorHealth is unable to sponsor visas.</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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CURRENT/PRIOR ACGME ACCREDITED GRADUATE MEDICAL EDUCATION TRAINING			
Specialty	Start Date	End Date	Institution
Medical School(s)			
Name of Medical School	Start Date	End Date	Degree
Graduate Program(s)			
Name of School	Start Date	End Date	Degree
Undergraduate Program(s)			
Name of School	Start Date	End Date	Degree

Board Certification / Eligibility (Fellows Only)				
Specialty	Status	Date		
		Exam	Certified	Expiration
	<input type="checkbox"/> Certified <input type="checkbox"/> Eligible			
	<input type="checkbox"/> Certified <input type="checkbox"/> Eligible			
	<input type="checkbox"/> Certified <input type="checkbox"/> Eligible			
	<input type="checkbox"/> Certified <input type="checkbox"/> Eligible			
Medical Licensure				
State	#	Expiration Date	Status	
			<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Revoked	
			<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Revoked	
			<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Revoked	
			<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Revoked	
			<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Revoked	
DEA Information				
Do you have a current DEA?		<input type="checkbox"/> Yes <input type="checkbox"/> No	DEA #	Expiration Date
Do you have a DEA DATA Waiver Buprenorphine?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, how many patients?	
Letters of Recommendation/Reference				
Please list the names of the 3 physicians, who you have known for a year or more, who you have requested letters of recommendation from. Letter writers must be willing to attest to that they have worked with you and in what capacity. Recent graduates of less than 5 years, must list their Program Director as a letter writer.				
Name and Credentials	# Yrs Known	Title	Email	
Comments:				
USMLE /COMLEX Date Passed				
Step 1	Step 2 CK	Step 2 CS	Step 3	

Other Information	
Are you eligible for Medical Staff Privileges?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you eligible for full medical licensure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you responded "no" to any of the above questions, please provide a detailed explanation.	
Are you precluded from enrolling as a Medicare/Medicaid provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had a prior board action taken against your medical license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had your medical staff privileges revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Were you placed on probation during residents for either academic or performance reasons?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been convicted of a misdemeanor or felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you responded "yes" to any of the above questions, please provide a detailed explanation.	

Required Documentation
Residents
<ul style="list-style-type: none"> • Copy of Medical School Diploma • Medical Student Performance Evaluation (MSPE) • Medical School Transcripts • USMLE/COMLEX Steps 1-2, 3 if PGY2+ • ACGME Milestone Evaluations from current program • Current curriculum vitae • 3 letters of recommendation from physicians who can speak to your clinical practice • One-page personal statement describing your interest in the specialty to which you have applied and your career goals upon completion of residency • Program Directors letter for prior GME training and an ACGME credited program to include dates of training completed
Fellows
<ul style="list-style-type: none"> • Copy of medical school diploma • Copies of diploma from residency and any other prior fellowships • Final Summative Evaluation from residency and any other prior fellowship programs • Medical School Transcripts • USMLE/COMLEX Steps 1-2, 3 if PGY2+ • Current curriculum vitae • 3 letters of recommendation from physicians who can speak to your clinical practice • One-page personal statement describing your interest in the specialty to which you have applied and your career goals upon completion of fellowship • Professional liability application

By signing this application, I attest to the following statements.

To the best of my knowledge and based on the information available to me, I have not been subjected to any investigations, disciplinary actions, or administrative proceedings that would impact my eligibility for medical license or as a medical insurance provider. Additionally, I have not received any notifications, warnings, or formal communication indicating any issues or concerns related to my eligibility. Furthermore, I attest that I have not had any medical board or medical staff privileges revoked or any remedial actions against me.

Signature	Date

Please submit your complete application and all the required accompanying documentation in a single PDF file to the program email you are applying to. Incomplete applications will not be reviewed.

Residency Program

- Dermatology DermResidency@honorhealth.com
- Family Medicine: FMResidency@honorhealth.com
- Internal Medicine IMResidency@honorhealth.com
- Physical Medicine & Rehab PMRresidency@honorhealth.com
- General Surgery GSResidency@HonorHealth.com

Fellowship Program

- Addiction Medicine AddictionMedicine@honorhealth.com
- Cardiovascular Disease CVDfellowship@honorhealth.com
- Clinical Informatics Cifellowship@honorhealth.com
- Electrophysiology EPfellowship@honorhealth.com
- Gastroenterology Gastroenterologyfellowship@honorhealth.com
- Geriatric Medicine Geriatricsfellowship@honorhealth.com
- Hospice and Palliative Medicine HospiceandPalliativeMedicinefellowship@honorhealth.com
- Interventional Cardiology ICfellowship@honorhealth.com
- Surgical Critical Care SCCfellowship@honorhealth.com
- Vascular Surgery VSFellowship@honorhealth.com