

Malpractice History

If answer to any of the following questions is YES, please provide full details on a separate sheet. Include date of occurrence, description of events and current status.

YES NO

1. Has your professional liability insurance coverage ever been terminated or denied by action of the insurance company?
2. Have you ever been denied professional liability insurance coverage?
3. Have you ever been named as a defendant or co-defendant in a malpractice action or claim?
4. Has any judgement or settlements been made on your behalf in professional liability cases within the last five years?
5. Have any professional liability suits or claims been filed against you, which are presently pending?
6. Have you ever been refused membership on a hospital medical staff?
7. Has your request for specific clinical privileges ever been denied or granted with stated limitations, or have your hospital privileges ever been suspended, revoked, or not renewed?
8. Have you ever resigned from a hospital staff while under investigation?

Disclaimer and Signature

My application has been filled out accurately, to the best of my knowledge. I have read, understand, and agree with the information provided herein.

Completed application submissions must include:

- Application
- Photo/headshot
- Curriculum Vitae
- Three letters of recommendation: Professional, Preceptor, Educator/Faculty
- Letter of Good Standing or Transcript from School
- Personal statement

Applications should be submitted via email by 5 pm PST **Monday, 9/13/21** to: APPfellowship@imailnv.org

Applications will not be accepted after this deadline

For the complete application timeline and information about the program, please visit: <https://hcpnv.com/fellowships/>

Please direct questions to Robert Vadovic, DNP, APN-c (Fellowship Program Director) or Veronica Tomlinson (GME Program Coordinator) at: APPfellowship@imailnv.org.

By signing, I agree and confirm that all of the information set forth in this application, including the attachments hereto, whether submitted by me or at my request at this time or a different time, are true and correct to the best of my personal knowledge. Material misstatements or omissions of fact concerning the matter addressed in this application, regardless of when discovered, shall constitute grounds for dismissal from Intermountain Healthcare APP Fellowship Program.

Applicant Signature: _____ Date: _____

Office Use Only

Date/Time Received by Program Coordinator: _____