Intermountain Healthcare

Advanced Practice Provider Fellowship Program Application

Cohort/Class #8: July 2023 – June 2023

Applicant Information

Full Name: ______________________________ Date: ______________
Last *First* *M.I.*

Home Address: ______________________________
Street Address *Apartment/Unit #*

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City *State* *ZIP Code*

Mobile Number: ______________________________ Email: ______________________________

Date of Birth: ______________ Place of Birth: ______________________________

Languages Spoken (other than English): ______________________________

Are you a citizen of the United States? YES NO

If no, are you authorized to work in the U.S.? YES NO

Have you ever been convicted of a crime? YES NO

If yes, explain: ______________________________

Education

Baccalaureate Education: ______________________________ Address: ______________________________

From: __________ To: __________ Did you graduate? YES NO Degree: ______________________________

Post-Graduate Education: ______________________________ Address: ______________________________

From: __________ To: __________ Did you graduate? YES NO Degree: ______________________________

Other Training: ______________________________ Address: ______________________________

From: __________ To: __________ Did you graduate? YES NO Degree: ______________________________

Other Training: ______________________________ Address: ______________________________

From: __________ To: __________ Did you graduate? YES NO Degree: ______________________________

Military Service

Branch: ______________________________ From: __________ To: __________

Rank at Discharge: ______________________________ Type of Discharge: ______________________________

If other than honorable, explain: ______________________________

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.

Applications must include:

- Signed application with all fields completed
- Photo/headshot appropriate for a professional application
- Curriculum Vitae / Resume
- Three letters of recommendation: 1) Professional Supervisor/Manager; 2) Preceptor; 3)Educator/Professor
- Letter of Good Standing from school *(regardless of whether you've graduated)*
- Personal statement

Applications, and required attachments, must be submitted via email by **the deadline reflected on the website** to: APPfellowship@imail.org. *Applications will not be accepted after this deadline. Incomplete applications will not be considered.*

For the complete application timeline and information about the program, please visit: https://hcpnv.com/fellowships/.
Please direct questions to our program coordinator at: APPfellowship@imail.org.

Disclosure: After completing the 12-month program, fellows transition to independent providers and are assigned to a "home" clinic for two additional years. The total commitment, if accepted into the program, is three (3) years.

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 matters addressed in this application, regardless of when discovered, shall constitute grounds for dismissal from Intermountain Healthcare's APP Fellowship Program.

Applicant Signature: ______________________________ Date: ______________

Are you a former or current Intermountain Healthcare employee? Yes No

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Office Use Only

Date/Time Received by Program Coordinator: ______________________________