

**APPLICATION FOR
DEVELOPMENTAL BEHAVIORAL FELLOWSHIP TRAINING**

JFK Partners
University of Colorado Denver
13121 E. 17th Ave, C234
Aurora, CO 80045
303-724-7673

Date of Desired Appt: _____ Social Security #: _____

Full Name: _____ Board Certification: _____ Certificate #: _____
Please enclose a photocopy of the certificate. If you are not certified, have you applied to take the exam? _____

Current Address: _____
City, State Zip

Permanent Address: (if different) _____
City, State Zip

Daytime Phone: _____ Evening Phone: _____

US Citizen Yes No Military Status: _____
Do you speak a second language? (specify) _____

Sex** M F Marital Status** _____ Children** _____
** Answers are optional

Pre-Medical Education:

Give names of schools, addresses, dates of attendance and degrees

Medical Education:

Give names of schools, addresses, dates of attendance and degrees

Residency Training:

Give name of hospital, address, type of program, and dates

List all activities since medical school graduation in chronological order, including sabbaticals and non-medical activity. Please leave no time gaps. (Use separate page if needed.)

Special Training Not Listed Above: (assistantships, practice, etc.): _____

Licensed to practice in which states: _____

Publications and Research (attach a bibliography of your work and attach a copy of each publication)

Please answer the following. If the answer to any question is YES, you must attach a letter explaining the circumstances. With regard to legal action, describe the events which gave rise to the case, the parties involved, the status and merits of the case and outcome, if any.

Health Status:

1. Date of last complete physical examination: _____
2. Present health status: Good Fair Poor (If fair or poor, state reasons on a separate sheet.)
3. Have you been hospitalized in the past five years? Yes No
4. Have you been denied health, life, or disability insurance? Yes No
5. Do you have any limitations on your health, life, or disability insurance? Yes No
6. Have you had any problems with alcohol or drug dependency? Yes No
7. Are you currently taking medication that may affect your clinical judgements or motor skills?
 Yes No
8. Are you currently under any limitations, in terms of activity or workload? Yes No
9. Are you currently under the care of a physician for any significant, acute, or chronic disorder? Yes No
10. Do you have any physical/mental impairment which affects your ability to practice medicine?
 Yes No

Professional Information

1. Has your license been denied, limited, suspended, or revoked in any state? Yes No
2. Has any formal complaint been filed against you in any state which may result or has resulted in probation, revocation, or suspension of your license? Yes No
3. Has your employment or privileges at any hospital been denied, reduced, suspended, terminated, or put on probation or have you resigned while under investigation related to possible incompetence or improper professional conduct? Yes No
4. Have proceedings been initiated which may result in probation, reduction, or suspension of your privileges at any hospital? Yes No
5. Has your membership in any professional or medical societies ever been terminated? Yes No
6. Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program? Yes No
7. Have you ever been or are you now the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program? Yes No

8. Has your narcotics registration certificate ever been denied, limited, suspended, or revoked?
 Yes No
9. Is your narcotics registration certificate currently being challenged? Yes No

Legal Actions

1. Have you ever been named as a defendant in any criminal proceedings? Yes No
2. Have you been convicted of or entered a guilty or nolo contendere plea to a felony? Yes No
3. Have any professional liability suits been filed against you? Yes No
4. Have any professional liability suits been filed against you which are presently pending? Yes No
5. Have any judgements or settlements been made against you in professional liability cases? Yes No

Names and addresses of at least three medical professionals whom you wish to use as references. These letters should be sent as soon as possible after the submission of this application directly to: Cordelia Robinson, PhD, RN, JFK Partners/UCHSC, 4200 E. 9th Ave., C221, Denver, CO 80262.

1. _____
2. _____
3. _____

If you are a recipient of a fellowship stipend or other professional grant, give name and donor:

Donor Name: _____ Duration: _____ Amount: _____

I certify that the statements contained in this application are true and complete. I understand that this information will be verified and that any omissions or distortions will significantly prejudice my application. I authorize the appropriate administrative officials of JFK Partners, the Child Development Unit of The Children’s Hospital or the University of Colorado Health Sciences Center (TCH/UCHSC) to make inquiries and investigations necessary to establish my professional qualifications, my adherence to the ethics of my profession, my good reputation, and ability to work with others. I also authorize any person, hospital, or health care facility to whom JFK/TCH/UCHSC makes appropriate inquiries, to disclose to JFK/TCH/UCHSC all information and facts known or believed by them, related to my professional qualifications. As a condition of this application, I hereby release all the above parties from any liability for such inquiries and disclosures relating to my professional qualifications.

Signature

Date