

Institution:	City, State, Country:
Did you graduate? Yes No Graduation Date:	Degree:
Honors:	

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Did you graduate? Yes No Graduation Date:	Degree:
Honors:	

INTERNSHIP & RESIDENCY

*Please list all internships and residencies, beginning with the most recent:

Facility:	City, State, Country:
Type: (Circle one) Internship Residency Start Date:	End Date: Completed? (Circle one) Yes No
Specialty:	Program Director:

Facility:	City, State, Country:
Type: (Circle one) Internship Residency Start Date:	End Date: Completed? (Circle one) Yes No
Specialty:	Program Director:

Facility:	City, State, Country:
Type: (Circle one) Internship Residency Start Date:	End Date: Completed? (Circle one) Yes No
Specialty:	Program Director:

FELLOWSHIPS

* List all academic fellowships, beginning with the most recent:

Facility:	City, State, Country:
Start Date: End Date:	Completed? (Circle one) Yes No
Specialty:	Program Director:

Facility:	City, State, Country:
Start Date: End Date:	Completed? (Circle one) Yes No
Specialty:	Program Director:

TEACHING APPOINTMENTS

* List all teaching appointments, beginning with the most recent:

Institution:		City, State, Country:	
Start Date:	End Date:	Completed? (Circle one) Yes No	
Type of Appointment:		Department Chief:	

Institution:		City, State, Country:	
Start Date:	End Date:	Completed? (Circle one) Yes No	
Type of Appointment:		Department Chief:	

BOARD STATUS

* List all present and previous boards

Board Name	Yes or No Certified?	Yes or No Eligible?	Dates: From - To

LICENSES Do you currently hold a New York State License? YES NO

*Please include all states in which you are currently licensed or have held in the past, beginning with the most recent:

State	Certification #	License #	Expiration Date	Active or Inactive

DEA Do you currently hold a DEA? YES NO

DEA Registration #	Issue Date	Expiration Date

NYS LIABILITY Do you currently hold New York State Professional Liability Insurance? YES NO

Carrier Name	Carrier Address	Policy #	Effective Date	Expiration Date	Type of Coverage/Amount

Do you currently have hospital affiliations or have had them in the past? YES NO

If YES Include all current and past affiliations, dates and appointment status; type of privileges and restrictions:

Hospital	City/State	Dates (From – To)	Appointment Status

Have any of the following been denied, revoked, suspended, sanctioned, reduced, limited, monitored, placed on probation not renewed or voluntarily relinquished to avoid possible disciplinary action in any jurisdiction:

- | | | |
|--|------------------------------|-----------------------------|
| 1. Medical, Dental or other professional license | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Controlled Substance Registration (DEA) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Academic Appointment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Membership in or affiliation with any health care facility staff | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Clinical privileges at any health care facility | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Prerogatives or rights at any health care facility | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Professional society membership or fellowship | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Board Certification | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Professional liability insurance | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Participation in any private, Federal or state insurance program (i.e. Medicare, Medicaid) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answered "Yes" to any of the above, explain in detail including, date, city, state, country, etc.

Additional Questions:

- | | | |
|--|------------------------------|-----------------------------|
| 1. Have you ever been the subject of any professional misconduct proceeding or sanctions? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you ever had any misdemeanor or felony charges brought against you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have any judgments or settlements been rendered against you in a professional liability case? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Have there ever been any findings or have you ever been found to be in violations of patient rights? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Have you ever received notice of malpractice actions which are pending? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Do you have any physical or mental disorders which may interfere with the practice of your discipline/specialty including alcohol or drug dependence? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answered "Yes" to any of the above, explain in detail explain in detail including, date, city, state, country, etc.

PRIOR INSURANCE ENROLLMENT / PROVIDER NUMBERS:

Medicare UPIN# _____ VIA NYS _____ Or other State _____

Community Blue, Blue Cross/Blue Shield Provider # _____

Independent Health Provider # _____

Univera Current Provider # _____

Other Current Provider # _____

NPI # _____

PROFESSIONAL REFERENCES

Name	Occupation	City/State	Phone #

Copies of the following are required to be turned in with this application:

Document	Circle One:
1. Curriculum Vitae/Resume	Enclosed N/A
2. Professional Degrees	Enclosed N/A
3. Residency Certificates(s)	Enclosed N/A
4. Fellowship Certificate(s)	Enclosed N/A
5. Board Certifications	Enclosed N/A
6. ECFMG Certificate/Number, If foreign graduate	Enclosed N/A
7. NYS License	Enclosed N/A
8. NYS License Registration Certificate – Signed	Enclosed N/A
9. DEA Certificate	Enclosed N/A
10. NYS Liability Insurance Certificate	Enclosed N/A
11. NPI Notice	Enclosed N/A
12. CME's for past 3 years (listing or certificates)	Enclosed N/A
13. Most recent copy of Infection Disease Control Training	Enclosed N/A

Applicant Printed Name

Applicant Signature

Date

This application must be completed in its entirety. When completed, please forward, along with the requested copies to:

Lionel R. John Health Center
Attention: Human Resource Office
PO Box 500
Salamanca, NY 14779

* Please write "CONFIDENTIAL" on your envelope



THE SENECA NATION OF INDIANS HEALTH DEPARTMENT

Read the following statement carefully and acknowledge with your signature:

I understand that the SNI is relying upon all of the representatives, both written and oral, which I have made or do during the entire process of applying for employment with the SNI. I acknowledge that the SNI has the right to investigate any job related information that the SNI believes relevant include, but not limited to, employment history and educational background. I hereby release and agree to hold the SNI harmless from all liability resulting in any way from such investigation and from all attorney fees resulting from any legal action I may institute which is within the scope of this waiver.

I also authorize my former employers, schools and personal references to provide any information they may have regarding me. I hereby release them and their company from all liability for divulging the same.

I hereby understand and agree that my employment is at will, that nothing in this application or in any other company document shall be deemed to create any contract of employment between me and the SNI and that my employment can be terminated at anytime by myself or the SNI for any or no cause. I understand and agree that any statements to the contrary, whether oral or written, are expressly disavowed and are not to be relied upon by me.

I understand that if I make any false statements, misrepresentations, or omission in the application process that I may be discharged at anytime during my employment and I agree to hold the SNI and persons named herein harmless in that event.

Applicant Printed Named

Applicant Signature

Date



THE SENECA NATION OF INDIANS HEALTH DEPARTMENT

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize the Seneca Nation of Indians to investigate my former employment records as indicated on my resume of Seneca Nation of Indians/Seneca Nation Health Department Application for employment in consideration of the position(s) applied for.

I further authorize work related references to be supplied to the Seneca Nation of Indians Human Resources Office.

I hereby release the Seneca Nation of Indians, its employees, officers and directors from all liability for damages arising out of the furnishing of this information as request by me.

Applicant Printed Named

Applicant Signature

Date



THE SENECA NATION OF INDIANS HEALTH DEPARTMENT

SENECA NATION OF INDIANS EMPLOYEE DRUG AND ALCOHOL TESTING RELEASE

I, _____ hereby voluntarily agree to submit to any drug test requested and conducted by the Seneca Nation of Indians (the "Nation") which the Nation deems, in its sole discretion, to be reasonably necessary to provide its workers with a safe and health work environment.

I, _____ acknowledge that in the course of my employment, and as a prerequisite of employment with the Nation, I may be asked to submit to a random drug test and provide a urine, blood or breath sample and that I hereby consent to such tests in recognition of the Nation's efforts to maintain a drug and alcohol free workplace.

I have read, understand, agree and consent to the Nation's Drug and Alcohol testing policy as stated above, and recognize that decisions regarding my employment at the Nation may be made from the result of this test.

I AUTHORIZE the Nation, and its physician(s), nurses, technicians or agents to collect a specimen or specimens of my blood, breath or urine for chemical analysis.

I CONSENT to this test for drugs and alcohol and authorize the Nation's testing consultant(s) and testing laboratory to provide test results to the Nation. As a consequence of any positive result obtained by said test, I understand that I may not be offered a job with the nation or may be disciplined.

I hereby indemnify, release and forever discharge and hold the Nation and its subsidiaries and affiliated companies, agents and employees harmless from any and all claims, demands, judgments and legal fees arising out of or in connection with such tests, the results, or any lawful use of the results.

Printed Name: _____

Signature: _____

Social Security Number: _____

Date: _____