Graduate Medical Education Request for Training Pre-Application

Please complete, sign, and e-mail this form to AKMedicalStaff@providence.org, or fax it back to (907)212-4865 at least 2 months in advance of the requested rotation start date. Please note that **ALL** fields are required; if you are uncomfortable writing some of the information below, please call us at (907)212-3185.

In keeping with the philosophy and mission of Providence Health & Services Alaska (PHSA) Region, Providence Alaska offers a variety of experiences allowing individuals progressing in or towards the medical profession to work with professionals (physicians and allied health professionals) in their work setting. The Medical Staff Office supports education in the following medical professions: MD, DO, DPM, DDS, DMD, ANP, DNP, NNP, CNM, PA, RNFA, SA, PhD. Psychiatry, PhD. Psychology, and CCP.

Applicant Name:		Degree/Seeking:	Rotation Facility (PAMC, PKIMC, PVMC, PSMC, PSESH):
Medical Student Year (circle one): MS1 MS2 MS3 MS4	AHP Student (circle one): ANP-S CNM-S PA-S RNFA-S SA-S CCP-S Ph.D.-S	Resident (circle one): R1 R2 R3 R4 R5	Fellow:
Email Address:		Contact Number:	DOB:
Supervising Physician:		Rotation Specialty:	Rotation Dates (MM/DD/YYYY – MM/DD/YYY):
In what state(s) do you hold licensure, if applicable?	Have you ever been excluded from Medicare, Medicaid, or any healthcare program as identified on the Government Services Agency "Excluded Partied Listing System" or the Health and Human Services Officer of the Inspector General "Excluded Individual Search"? (Circle one): **YES** **NO**		
Medical/Professional School:		School Coordinator Contact Name & Email:	Graduation Year
Residency Program:		Program Coordinator Contact Name & Email:	Graduation Year
Fellowship Program:		Program Coordinator Contact Name & Email:	Graduation Year

By signing below, I attest that the information provided on the pre-application is accurate, complete, and fairly represents my training and current expertise. I understand and agree that any misrepresentation, misstatement, or omission from this application request, whether intentional or not, may constitute cause to not be provided an application as requested. I understand that in the event of discovery of such an event, or if I do not meet the minimum criteria of Providence, I will not be provided an application and I will not be entitled to any hearing or appeal rights that are contained in the Hospital Bylaws, Policies, or other regulations. I understand that with the information I have provided above, basic steps to understand my training and background may be checked to further determine my eligibility for graduate medical education privileges at Providence. I formally request an application for graduate medical education privileges and certify that I am currently competent to perform the privileges associated with my degree level. I agree that I will provide all necessary documentation, as required, in support of the application for privileges. I also know of no health condition or inability to perform that, without reasonable accommodation, would impair my ability to competently perform the privileges that I may be granted.

Applicant Signature: _____ Date: _____