Women's Health Faculty Development Year
133 Benmore Drive, Suite 201
Winter Park, Florida 32792
Tel: 407-303-7757 | Fax: 407-303-7775

Application for Women's Health Jr. Faculty Position

APPLICANT INFORMATION			
Last Name	First Name	M.I.	Credentials
Gender ☐ Male ☐ Female	Date of Birth		
Home Address	City, State, Zip		
Preferred Phone	Email		
Language (s)			
Citizenship: ☐ US Citizen ☐ US Permanent ☐ Green Card *VISA: Unfortunately, we are unable to sponsor J-1 visas			

Medical School Information	
School Name	Graduation Date
Address	City, State, Zip
Residency Information	
Institution/ Program	Program Director
Address	City, State, Zip
Specialty	Start Date Anticipated Graduation Date

☐ Board Certified ☐ Board Eligible	State of Board Certification	Specialty Date

Test Scores/ License/ Certifications		
Date Score ☐ Intraining 1 ☐ Intraining 2 ☐ Intraining 3	Date Score ☐ USMLE/ COMLEX 1 ☐ USMLE/ COMLEX 2 ☐ USMLE/ COMLEX 3	Date Score ☐ FP Board Exam
Expiration Date ☐ BLS ☐ ACLS ☐ NALS/ NRP ☐ ALSO ☐ Nexplanon Certified: Does not expire	Medical License # State Expiration Date	DEA # Expiration Date

Please include your Curriculum Vitae and a personal statement. References should be made to previous work experiences, as well as professional interest and achievements. Reasons for desiring the development year program, as well as future plans upon completion of the program should be specifically addressed. Please also explain any affirmative answers listed below and any interruptions in your medical education.

Have you ever:

Yes ☐ **No** ☐ been convicted of a crime?
Yes ☐ **No** ☐ had your medical license suspended or revoked?
Yes ☐ **No** ☐ had a malpractice judgment against you?
Yes ☐ **No** ☐ been suspended or had privileges limited?

Applicant Checklist	
☐ Application Completed	☐ Residency Verification (Mailed Directly to Program)
☐ Attach Recent Photograph	☐ Verified Procedure Log (Mailed Directly to Program)
☐ Attach Personal Statement (Limit to 1 page)	☐ ***Copy*** of USMLE/ Comlex Scores
☐ Curriculum Vitae	☐ ***Copy*** of Intraining Examination Scores
☐ 3 Letters of Recommendation (Mailed Directly to program)	☐ ***Copy*** of ECFMG Certificate (if applicable)
☐ References contact Information (entered below)	☐ ***Copy*** of Medical License
☐ Medical School Verification (Mailed Directly to Program)	☐ ***Copy*** of DEA
☐ ***Copy*** of Medical Diploma	Please send all supporting documents to: Program Coordinator

References Contact Information: *Please supply letters of reference, including your program director and one faculty member in your area of interest.*

Name/ Title: Institution: Address: Phone Number:
Name/ Title: Institution: Address: Phone Number:
Name/ Title: Institution: Address: Phone Number:

Release of information

I am applying to your Women's Health Jr. Faculty Position, available to begin on July 1st. I understand that, in the event my application is accepted for appointment as a Junior Faculty, I authorize an investigation of all statements contained in the application and my curriculum vitae and do hereby release any and all persons, companies, or agencies responding to such investigations from any liability, for any damages due to releasing any information pertaining hereto. I further understand that misrepresentation of facts asked for on this application is cause for rejection of this application or for subsequent dismissal from appointment as Junior Faculty, no matter when discovered. If I am employed, I agree to comply with and be bound to all rules and regulations of AdventHealth and the Family Practice Residency and Women's Health Faculty Development Year Program.

_____

Signature of Applicant Date

APPLICATION STATUS (FOR INTERNAL USE ONLY)		
☐ Application Received	☐ Supporting Documents Received	☐ Administrative Review
☐ Interview	☐ Interview Date:	☐ Decline

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Medical Degree Verification Form

Applicant completes section 1-3. Medical School authorized representative must complete section 4 and mail or fax directly to:

Women's Health Program Coordinator
133 Benmore Drive, Suite 201
Winter Park, Florida 32792
Fax: 407-646-7775

Section 1
Name of Medical School:
Street Address:
City, State, Zip- Country

Section 2
Applicant Name:

Section 3
Date of Birth:

Section 4
Type of Degree: _____ Date Degree Received: _____

Authenticate by signature and school seal
(If no seal is available, form must be notarized)

SEAL

_____
Signature

_____
Print Name

_____
Title

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Post-Graduate Training Verification Form

Please have this form completed by the Chairman/ Director of the Post-graduate training program you attended. Please mail or fax this form directly to:

Women's Health Program Coordinator
133 Benmore Drive, Suite 201
Winter Park, Florida 32792
Fax: 407-646-7775

Name of Institution:
Department:
Street Address:
City, State, Zip- Country

Name of Resident:	
Internship/Residency/Fellowship: From:	To:
State Date:	
Completion Date:	
Specialty:	
Levels Completed (check all that apply):	
PGY 1 ☐ PGY2 ☐ PGY3 ☐ PGY4 ☐ PGY5 ☐	

Authenticate by signature and Institution seal
(If no seal is available, form must be notarized)

SEAL

_____
Signature

_____
Print Name

_____
Title

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Procedure Log Verification Form

Mail or fax this form directly to:

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Please verify the number of procedures logged for the following:

_____Vaginal Deliveries (50 Required)

_____Cesarean Deliveries

_____Colposcopies

_____Nexplanon insertions/ removals

_____Intrauterine Device (IUD) Insertions

_____ Endometrial Biopsies (EMB)

_____
Program Director or Coordinator Signature/ Date

_____
Print Name

_____
Title