NOVA SOUTHEASTERN UNIVERSITY
Health Professions Division
College of Osteopathic Medicine
Office of Faculty Credentials

Dear Applicant:

Thank you for your interest in applying for a faculty appointment with Nova Southeastern University College of Osteopathic Medicine. The review of your appointment request is primarily based upon your active involvement in teaching our medical students, interns, and/or residents.

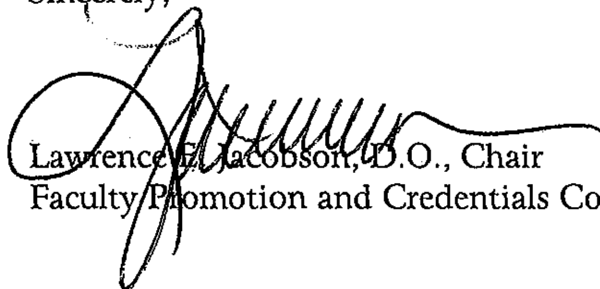
The enclosed application for faculty appointment should be submitted with the following documents:

- Curricula Vitae
- Current Medical License
- Medical Diploma
- ECFMG (if applicable)
- Degree Translation (if applicable)
- Internship Certificate
- Residency Certificate
- Board Certification
- DEA Registration
- Malpractice Insurance
- Recommendation Letter from Peer or Director of Medical Education

Please return the completed application packet to Annette Clarke, Office of Faculty Credentialing, NSUCOM, 3200 South University Drive, Fort Lauderdale, FL 33328-2018. After receipt of this information, please allow 90 days for processing. You will be notified of your application status within this time period. If any of the requested information is not received, this will result in a delay in the application process.

Your interest in participating in our educational program is greatly appreciated. If you have any questions feel free to contact Annette at (954) 262-2141.

Sincerely,



Lawrence E. Jacobson, D.O., Chair
Faculty Promotion and Credentials Committee

College of Osteopathic Medicine • College of Pharmacy • College of Optometry
College of Allied Health and Nursing • College of Medical Sciences • College of Dental Medicine
3200 South University Drive • Fort Lauderdale-Davie, Florida 33328-2018
(954) 262-2141 • Fax: (954) 262-2250

College of Osteopathic Medicine
FACULTY APPOINTMENT APPLICATION

Please note: A faculty appointment is contingent upon recommendation by the department chair and approval by the dean.

Name: ____
(Last name) (First name) (Middle initial)

List all degrees: ____

Office name: ____

Preferred Mailing Address: ____

Telephone: ______________ Fax: ______________ Email address: ______________

Residence: ____

____

Telephone: ______________________ Fax: ______________________

AOA/AMA/ or other membership: ______________________(For CME reporting purposes)

Specialty(ies): ____

Area of certification(s): ____

Specialty board(s): ____

If not certified are you board eligible? Yes_______ No_______

Florida licensure number: ______________________ Expiration date: ______________

DEA registration number: ______________________ Expiration date: ______________

Fellowship: (Specialty/Subspecialty—list institution name and date)

____

____

Current academic appointments:

Position(s)	Dates

Current hospital affiliations:

____

____

Questionnaire:

Are you currently teaching NSUCOM medical students, interns, or residents?

☐ Yes ☐ No If yes, please indicate teaching site:________________

Areas of teaching: ☐ Campus Lecturing ☐ Small Group ☐ Office

☐ Hospital/Clinic ☐ Other________________

How long have you beenteaching?________________

In what capacity are you teaching? (please check one in each category)

Appointment Status	Teaching Status	Levels of Teaching
☐ Full-time college employee	☐ Clinical preceptor	☐ First- and second-year students
☐ Part-time college employee	☐ Instructor	☐ Third- and fourth-year students
☐ Clinical faculty	☐ Guest lecturer	☐ Interns
	☐ IGC mentor	☐ Residents

How long have you been in practice? ________________

Do you practice in a hospital or ambulatory setting? ________________

Location: Rural ________ Inner city ________ Urban ________ Suburban ________ Small town ________

Has your license to practice medicine or any professional registration (e.g., DEA certificate) in any jurisdiction ever been limited, on probation, suspended, or revoked, or is such action pending? _____ No _____ Yes*

Were there any prior malpractice actions (claims, suits, or judgments made) filed against you in the past five years in this or any other state? _____ No _____ Yes*

Are there any malpractice actions pending against you in this or any other state? _____ No _____ Yes*

Has your membership and/or clinical privileges ever been reduced, suspended, revoked, or not renewed at a health care institution? _____ No _____ Yes*

The provision of this information is voluntary and we request it for reporting purposes only. This information will not be used in any discriminatory manner.

Social Security #:________________ D.O.B.:_____/_____/_____ Male: _____ Female: _____

Ethnicity: White (not of Hispanic origin) ☐ African American (not of Hispanic origin) ☐ Hispanic Origin ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐
Other: (please specify) ________________

U.S. Citizen: Yes ______ No ______ Resident Alien: Yes ______ No ______ Permanent Resident: ______

I certify that answers given herein are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application as may be necessary in arriving at a decision. I understand that false or misleading information given in my application or interview(s) may result in a failure to approve/renew my faculty appointment. I am required to abide by all rules and regulations of the university.

________________ ________________
Signature of applicant Date

Please attach a copy of your professional license, internship certificate, residency certificate, board certification(s) (if applicable), medical license, DEA registration, curriculum vitae, and malpractice certificate.
For full-time faculty, a certified (official) transcript is required from your health professional school.

NOTE: For an appointment at the clinical associate professor or clinical professor level, evidence of scholarly activities such as recent publication(s) of original articles or reviews in a refereed publication or journal, or scientific presentations and program development should be submitted.

*If yes, please attach supporting documentation.

We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, sexual orientation, or any other legally protected status.

CONSENT TO RELEASE INFORMATION

I, hereby consent to the release to or by any hospital, educational institution, governmental agency, physician, professional society, or other person possessing or requiring the same, whether or not listed above, of any and all information in any way pertaining to my personal character, training, experience, or professional competence which is believed to be true and relevant.

I, hereby, waive any and all claims, of every kind or description, which I may or could have and indemnify and hold harmless any and all individuals and organizations, or their authorized representatives who provide this information, in good faith and without malice, from any claim, and all costs and expenses, including attorney's fees, in connection herewith.

PRINT NAME:____________________________________

SIGNATURE______________________________________

DATE:____