Thank you for choosing OhioHealth to be a part of your educational experience.

APPLICATION PROCESS

The ideal candidate for the OhioHealth Quality and Safety Fellowship will have completed an ACGME or AOA accredited residency program and will be board certified or board eligible.

Directions: Please be sure to thoroughly read and complete every section of this application. The application will not be considered complete until all of the additional items listed in **Section B** of this application have been received. The completed application should be submitted via email to the OhioHealth Riverside Methodist Hospital Graduate Medical Education coordinator, at **Rachel.Kapusta@ohiohealth.com**

Application deadline is September 1st.

You will be notified on the status of your application within two weeks of submission of all requested documents. Applicants must be available to interview in person if so requested.

Please allow 10 business days before contacting the program for a response.

SECTION A: Applicant Information

Name: _____ **Date of application:** ___/___/____
Last First MI

Address:

_____

City: _____ **State:**_____ **Zip:** _____

Cell Phone: (_____) _____ **E-Mail Address:** _____

DOB: ____/_____/_____ **Gender:** ❑ male ❑ female ❑ other/prefer not to state

Education and Experience

❑ **Medical School training:**

Name of University _____

Full Address: _____

Date of Training: ____/____/_____ to ____/____/_____ Accredited by ❑ AOA ❑ LCME

❑ **Residency training:**

Full Program Name (include specialty): _____

Full Address: _____

Program Director Name: _____

Dates of Training: ____/____/_____ to ____/____/_____ Accredited by ❑ AOA ❑ ACGME

Full Program Name (include specialty): _____

Full Address: _____

Program Director Name: _____

Dates of Training: ____/____/_____ to ____/____/_____ Accredited by ❑ AOA ❑ ACGME

❑ **Fellowship training:**

Full Program Name (include specialty): _____

Full Address: _____

Fellowship Director Name: _____

Dates of Training: ____/____/_____ to ____/____/_____ Accredited by ❑ AOA ❑ ACGME ❑NA

❑ **Clinical Practice:** I am currently in practice (please list past 10 years, attach additional if necessary):

Practice Name: _____

Practice Address: _____

Practice Phone: _____

Dates of employment: ____/____/_____ to ____/____/_____

Practice Name: _____

Practice Address: _____

Practice Phone: _____

Dates of employment: ____/____/_____ to ____/____/_____

Practice Name: _____

Practice Address: _____

Practice Phone: _____

Dates of employment: ____/____/_____ to ____/____/_____

❑ I have medical staff privileges at an OhioHealth hospital.

- ❑ Doctors Hospital
- ❑ Dublin Methodist
- ❑ Grant Medical Center
- ❑ O'Bleness Hospital
- ❑ Riverside Methodist
- ❑ Other: _____

❑ I have medical staff privileges at _____(Name of Health)

❑ **Teaching experience:**

- ❑ I am a clinical instructor at Ohio University HCOM.
- ❑ I am a clinical instructor at _____ (name of University COM).

Licensure

State Medical Licensure

❑ I hold a medical license in the state of Ohio.

License Number: _____ Dates Valid: _____

❑ I hold a medical license in another state.

State: _____ License Number: _____ Dates Valid:_____

Have you ever been convicted of a misdemeanor? ❑ yes ❑ no
Have you ever been convicted of a felony or misappropriation of funds? ❑ yes ❑ no

Describe if yes: _____

Are there any actions or proceedings which have involved the suspension or revocation of your license or training permit in any state or jurisdiction? ❑ yes ❑ no

Describe if yes: _____

SECTION B: Required Additional Items

The items listed below must be received by Riverside Methodist Hospital Graduate Medical Education prior to application review.

❑ Current CV

❑ Personal Statement describing your interest in this fellowship

❑ 2 letters of recommendation, at least one of which must be from your residency training Program Director or your current employer

Please have your references email letters of recommendation to:
Rachel.Kapusta@ohiohealth.com

SECTION C: Acknowledgement

Authorization and Release: To the best of my knowledge, the information that I have provided in this application is true and free of any consequential omissions. I authorize OhioHealth Riverside Methodist Hospital Graduate Medical Education to verify any of the information I have provided, and further authorize any of the schools, institutions, or persons listed to provide any information about me contained in their records. If I am accepted for any position by OhioHealth Riverside Methodist Hospital, I agree to abide by the policies, rules, regulations and practices of OhioHealth Riverside Methodist Hospital.

Signature: _____ **Date:** _____

Printed Name: _____