

MICHIGAN STATE
UNIVERSITY

COLLEGE OF HUMAN MEDICINE

APPLICATION FOR CLINICAL or ADJUNCT FACULTY APPOINTMENT

MSU's Clinical/Adjunct faculty appointment system is used for those individuals whose primary responsibility and source of income is outside MSU, but who agree to provide educational services in support of MSU's mission. Those appointed in this system are also referred to as "prefix" faculty. Appointment length varies but is generally for 3 years and is renewable. Promotion is based upon meeting established minimum criteria approved by the College of Human Medicine Advisory Council as well as specific department criteria.

Please type or print all information legibly. Incomplete applications or missing information may delay appointment!

CHM Community Affiliation: Flint Grand Rapids Traverse City
 Kalamazoo Lansing
 Saginaw Upper Peninsula

I am requesting appointment in the Department(s) of:

- Family Medicine
 - Medicine
 - Neurology/Ophthalmology
 - OB/Gyn/Repro Biology
 - Pediatrics & Human Development
 - Radiology
 - Psychiatry
 - Surgery
- Other: _____
- Uncertain – Please advise

(Note: If requesting appointment in more than one department, please indicate which department you wish to be your *primary* department.)

NAME (last, first, middle initial): _____

PREFERRED MAILING ADDRESS: Home Office Other

(Street/City/State/Zip): _____

SECONDARY MAILING ADDRESS: Home Office Other

(Street/City/State/Zip): _____

BUSINESS PHONE: (____) _____ HOME PHONE: (____) _____

CELL: (____) _____ FAX: _____ E-MAIL: _____

PRACTICE GROUP AFFILIATION (name and address if applicable): _____

DATE OF BIRTH: _____ U.S. CITIZEN? Yes No

IF NOT US CITIZEN: Permanent Resident Foreign National Type of Visa _____

Country of Citizenship: _____

SOCIAL SECURITY NUMBER: _____ GENDER: Male Female

ETHNICITY: Black Asian/Pacific Islander Hispanic Amer. Indian/Alaskan Caucasian

ANY RELATIVE EMPLOYED BY MSU? No Yes *(If yes, name, relationship, title, department): _____

EDUCATION:	Degree Earned	Major Field of Study	Institution	Year
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

POSTGRADUATE TRAINING

INTERNSHIP: Institution _____ Dates _____

RESIDENCY: Specialty _____ Institution _____ Dates _____

Specialty _____ Institution _____ Dates _____

FELLOWSHIP: Specialty _____ Institution _____ Dates _____

LICENSES: License Number _____ State _____ Date Issued: _____

License Number _____ State _____ Date Issued: _____

License Pending? _____ (indicate reason, e.g., new resident or out-of-state)

BOARD ELIGIBILITY/ CERTIFICATIONS

Certified? Yes No Specialty _____ Date Issued: _____

Certified? Yes No Specialty _____ Date Issued: _____

Eligible? Yes No Specialty _____ Date _____

PRIVILEGES:

Hospital _____ City/State _____

Hospital _____ City/State _____

Hospital _____ City/State _____

PREVIOUS UNIVERSITY EXPERIENCE

Institution _____ Position _____ Years: _____

Institution _____ Position _____ Years: _____

Is there any other information you would like us to know as we consider your application for appointment and rank? _____

PLEASE INCLUDE AN UPDATED CURRICULUM VITAE OR RESUME' WITH THIS APPLICATION

To the best of my knowledge, I certify that all information provided in this application is correct.

Signature: _____ Date: _____

* Office use only: MSU Conflict of Interest form is: Attached On File (previously submitted)