AMERICAN ACADEMY OF COSMETIC SURGERY

Application For
CLINICAL TRAINING PROGRAM IN COSMETIC SURGERY

❑ 1 year ❑ 2 year

Please type or print legibly.

Name:_____
First Middle Initial Last

Office Address:_____

_____ Telephone:_____
City State Zip

Home Address:_____

_____ Telephone:_____
City State Zip

Citizenship:_____ Naturalized?_____

Person to notify in case of emergency:_____

MILITARY RECORD:

Were you in the U.S. Armed Forces? ❑ Yes ❑ No If yes, what branch?_____

Rank:_____ Type of Duty:_____

List any special skills acquired during active duty:_____

_____

STATE MEDICAL OR DENTAL LICENSURE:

State:_____ Date:_____ License No._____

State:_____ Date:_____ License No._____

Drug Enforcement Administration No.:_____ Date:_____

SPECIALTY:_____ **SUBSPECIALTY:**_____

Board Certified (Date):_____ Board Certified (Date):_____

Board Eligible:_____ Board Eligible:_____

CATEGORY OF TRAINING DESIRED:

❑ General Cosmetic ❑ Facial Cosmetic ❑ Dermatologic Cosmetic

Have you passed:

1. National Board of Medical Examiners. Part 1, 2 and 3? ❑ Yes ❑ No
2. FLEX ❑ Yes ❑ No
3. ECFMG, FMGEMS – Education Commission for Foreign Medical Graduates/ Foreign Medical Graduate Examiners in Medical Science ❑ Yes ❑ No
4. National Board of Dental Examiners ❑ Yes ❑ No

Please enclose a copy of current:

- ❑ State License
- ❑ DEA – BNDD Certificate
- ❑ National Board Certificate, FLEX Certifcate and/or ECFMG/FMGEMS Certificate
- ❑ Malpractice Insurance Facing Sheet
- ❑ Medical School Diploma
- ❑ Signed, Unmounted (3" x 5 ") recent black and white glossy photograph
- ❑ Curriculum Vitae

Have any of the following ever been or are in the process of being denied, revoked, suspended, reduced, not renewed or voluntarily relinquished (by either resignation or expiration)?

1. Narcotic License, Drug Enforcement Administration or other controlled substances registration ❑ Yes ❑ No
2. License to practice medicine in any jurisdiction ❑ Yes ❑ No
3. Staff membership status or clinical privileges at any other hospital, clinic or health care institution ❑ Yes ❑ No
4. Membership/fellowship in local state, state, or national professional organizations ❑ Yes ❑ No
5. Specialty board certification/eligibility ❑ Yes ❑ No
6. License to practice any profession in any jurisdiction ❑ Yes ❑ No
7. Faculty appointment at any medical or other professional school ❑ Yes ❑ No

If your answers to any of the above questions are "yes", full details should be submitted on an attached sheet.

Please answer the following questions:

1. Do you have any health impairments that affect your ability in terms of skill, attitude or judgement to fully perform professional and medical staff duties? ❑ Yes ❑ No

2. While practicing, has your professional liability insurance carrier ever been sued for your actions within the past five (5) years? Please include any information on malpractice claims or suits against you as well as any malpractice claims or suits that have been filed against you. (If your answer is yes, include the name of present and past insurance carriers and their consent to the release information).

_____

_____

3. Are there now or have there ever been any criminal charges against you? ❑ Yes ❑ No

PROFESSIONAL REFERENCES

Please list the names and addresses of the three letters of reference you will be submitting with the attached information.

1. _____

_____

2. _____

_____

3. _____

_____

4. Enclose a letter of recommendation from your Residency Training Director.

DISCLOSURE / WAIVER

I certify that the information contained in this application form is complete and that I am fully capable and qualified for the training program category applied for. I understand that any significant misstatement in or omission from this application constitutes cause for dismissal from the program.

I authorize the American Academy of Cosmetic Surgery and its representatives to consult with and seek information regarding my present and past liability and qualifications. I authorize the Academy to obtain information regarding my present and past liability insurance coverage, including claims, suits, and settlements made, concluded or pending. I consent the Academy inspection of all records and documents that may be material to an evaluation of my professional ability and qualification to carry out the training program sought by me as well as my ethical qualifications for the training program.

I hereby release from liability all representatives of the Academy and their staff for their acts performed in good faith without malice in connection with evaluating me and my credentials. I further release from liability all representatives of the Academy and their staff who provide information (including otherwise privileged or confidential information) in good faith with or without malice to a representative of any other health care facility or organization of health care professionals concerning my application for the training program.

Signature_____ Date_____

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