PROVIDENCE Health & Services Alaska

REQUEST FOR TRAINING APPLICATION / PRE-APPLICATION

Rev. 10/17

Please complete this form, sign it, and e-mail back to medicalstaffoffice-pamc@providence.org, or fax it back to (907) 212-4865

Degree Types, eligible to request training application: MD, DO, DDS, DMD, DPM, CNM, ANP, PA, PhD, Surgical Asst, Dental Asst, Pathology Asst, Perfusionist

Applicant Name:	Degree/Seeking:	Rotation Specialty:

Medical Student:	AHP Student:	Resident:
☐ MS1 ☐ MS2 ☐ MS3 ☐ MS4	☐ ANP-S ☐ CNM-S ☐ PA-S ☐ RNFA-S ☐ SA-S ☐ PSYCH Intern/Student	☐ R1 ☐ R2 ☐ R3 ☐ R4 ☐ R5

We use an electronic application process at PAMC, so an e-mail address is required to receive your training application.

Address to E-mail Training Application links:		SSN:	DOB:
Who will be your supervising physician for this rotation?	Rotation Dates:	In what state(s) do you hold licensure, if applicable?	Contact # in case we have questions about your application:

Have you ever been excluded from Medicare, Medicaid or any healthcare program as identified on the Government Services Agency "Excluded Parties Listing System" or the Health and Human Services Officer of the Inspector General "Excluded Individual Search" ☐ Yes ☐ No

Medical/Professional School:	Grad Yr:	Residency Program:	Grad Yr:
Internship/Residency Program:	Grad Yr:	Fellowship Program:	Grad Yr:

I represent that the information provided on this pre-application is accurate, complete and fairly represents my training and current expertise. I understand and agree that any misrepresentation, misstatement, or omission from this application request whether intentional or not may constitute cause to not be provided an application as requested. I understand that in the event of discovery of such an event, or if I do not meet the minimum criteria of PAMC, I will not be provided an application and I will not be entitled to any hearing or appeal rights that are contained in the Hospital or Medical Staff Bylaws, Policies or other regulations. I understand that with the information I have provided above, basic steps to understand my training and background may be checked to further determine my eligibility for medical staff membership and privileges at PAMC.

I formally request an application for membership and privileges and certify that I am currently competent to perform the privileges selected above based on my training, recent experience and within the scope of my professional licensure. I will agree that I will provide all necessary documentation, as required, in support of the application for membership and privileges I receive. I also know of no health condition or inability to perform that, without reasonable accommodation that would impair my ability to competently perform the privileges I may be granted.

Signature: ______________________________ Date: ____________________