



**Cohort/Class # you are applying to:** \_\_\_\_\_  
 Submit to APPfellowship@imail.org during open recruitment

## Advanced Practice Provider Family Medicine Fellowship Program - St. George

### Applicant Information

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First M.I.

Home Address: \_\_\_\_\_  
Street Address Apartment/Unit #

\_\_\_\_\_

City State ZIP Code

Mobile Number: \_\_\_\_\_ Personal Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Languages Spoken (other than English): \_\_\_\_\_

YES NO YES NO

Are you a citizen of the United States? If no, are you authorized to work in the U.S.?

YES NO

Have you ever been convicted of a crime?

If yes, explain: \_\_\_\_\_

### Education

Baccalaureate School Name: \_\_\_\_\_ Address: \_\_\_\_\_  
YES NO

From: \_\_\_\_\_ To: \_\_\_\_\_ Did you graduate? Degree: \_\_\_\_\_

Post-Graduate School Name: \_\_\_\_\_ Address: \_\_\_\_\_  
YES NO

From: \_\_\_\_\_ To: \_\_\_\_\_ Did you graduate? Degree: \_\_\_\_\_

Other Training: \_\_\_\_\_ Address: \_\_\_\_\_  
YES NO

From: \_\_\_\_\_ To: \_\_\_\_\_ Did you graduate? Degree: \_\_\_\_\_

Other Training: \_\_\_\_\_ Address: \_\_\_\_\_  
YES NO

From: \_\_\_\_\_ To: \_\_\_\_\_ Did you graduate? Degree: \_\_\_\_\_

### Military Service

Branch: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Rank at Discharge: \_\_\_\_\_ Type of Discharge: \_\_\_\_\_

If other than honorable, explain: \_\_\_\_\_

## Malpractice History

*If answer to any of the following questions is YES, please provide full details on a separate sheet. Include date of occurrence, description of events and current status.*

YES NO

1. Has your professional liability insurance coverage ever been terminated or denied by action of the insurance company?
2. Have you ever been denied professional liability insurance coverage?
3. Have you ever been named as a defendant or co-defendant in a malpractice action or claim?
4. Has any judgement or settlements been made on your behalf in professional liability cases within the last five years?
5. Have any professional liability suits or claims been filed against you, which are presently pending?
6. Have you ever been refused membership on a hospital medical staff?
7. Has your request for specific clinical privileges ever been denied or granted with stated limitations, or have your hospital privileges ever been suspended, revoked, or not renewed?
8. Have you ever resigned from a hospital staff while under investigation?

## Disclaimer and Signature

**To be considered for the fellowship, applications must include:**

- Resume / CV
- Personal statement
- Letter of good standing from your school, or copy of unofficial grade transcript
- Photo/headshot appropriate for a professional application
- Completed and signed PDF application
- Letters of recommendation from a minimum of two of these three categories:
  - Work supervisor/manager
  - Clinical rotation preceptor
  - Educator/Professor (a dean's letter does not fulfill this category unless the dean taught you directly for a course, class, or semester)

**Submit this application, and accompanying documents, to [APPfellowship@jmail.org](mailto:APPfellowship@jmail.org).**

**Disclosure:** After completing the 12-month program, fellows transition to independent providers and are assigned to a "home" clinic for two additional years. The total commitment, if accepted into the program, is three (3) years.

*By signing, I agree and confirm that all of the information set forth in this application, including the attachments hereto, whether submitted by me or at my request at this time or a different time, are true and correct to the best of my personal knowledge. Material misstatements or omissions of fact concerning the matters addressed in this application, regardless of when discovered, shall constitute grounds for dismissal from Intermountain Health's APP Fellowship Program.*

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- |   |     |    |
|---|-----|----|
| 1. Are you a former or current Intermountain Health (or affiliate) employee?                                    | Yes | No |
| 2. Did you complete any shadowing or clinical rotations at Intermountain? If yes, in which clinic(s)/specialty? | Yes | No |
- 

### Office Use Only

Date/Time Received by Program Manager: \_\_\_\_\_