Cooper Medical School of Rowan University

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Personal Data Sheet for Faculty Appointment

The information requested is essential for our centralized faculty records, as we may be required to answer State and Federal inquiries on our faculty according to these categories. Please answer all questions.

Name:_____
Last Name First Name Middle Initial

Other Names You Have Used:_____

Social Security #:_____ **Gender:**_____

Ethnic Code (Please check all that apply)**:**

- ☐ **White, not of Hispanic origin** Origins in an of the original peoples of Europe, the Middle East, or North Africa
- ☐ **Black, not of Hispanic origin** Origins in any of the black racial groups of Africa
- ☐ **Hispanic** Origins of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture, regardless of race
- ☐ **Asian** Origins in any of the original peoples of the Far East, Southeast Asia, Indian subcontinent
- ☐ **American Indian or Alaska Native** Origins in any of the original people of North and South America (including Central America), and maintains tribal affiliation or community attachment
- ☐ **Native Hawaiian or other Pacific Islander** Origins in any of the original peoples of Hawaii, Guam, or other Pacific Islands

Date of Birth:_____ **Place of Birth:**_____

Citizenship:_____

Visa Status if not born in the USA (e.g., Permanent Resident, H1, J1)**:**_____

Home Address: **Office Address:**

Home Phone: (____) _____ **Office Phone:** (____) _____

Preferred Email Address: _____

FOR CLINICAL FACULTY ONLY:

Specialty:_____ **Subspecialty:** _____

Board Certified (Name of Specialty Board)**:**_____

Dates of Board Certification / Re-Certification (Specialty)**:**_____

Dates of Board Certification / Re-Certification (Subspecialty)**:**_____

Member of Alpha Omega Alpha (National Medical Honor Society)**:** ☐ **Yes** ☐ **No**

Name:_____
Last Name First Name Middle Initial

Current / Previous Employment:

1)_____
Most Recent Employer Full Street Address, City, State

_____
Employer Phone Number Supervisor's Name & Phone Number

_____
Your Title Dates Employed: From – To

2)_____
Next Employer Full Street Address, City, State

_____
Employer Phone Number Supervisor's Name & Phone Number

_____
Your Title Dates Employed: From – To

3)_____
Next Employer Full Street Address, City, State

_____
Employer Phone Number Supervisor's Name & Phone Number

_____
Your Title Dates Employed: From – To

May we contact your employer? ☐ **Yes** ☐ **No**

Please list the highest education completed:

_____
Name of School or University Address

_____
Degree Date Awarded Name under Which Attended

Please list all professional licenses and board certifications, including those held in more than one state:

Type of License / Certification:_____ State issued:_____

Type of License / Certification:_____ State issued:_____

Type of License / Certification:_____ State issued:_____

Have you ever been a subject of an investigation in an allegation of research misconduct? ☐ **Yes** ☐ **No**
(research misconduct if defined as fabrication and/or falsification of data or plagiarism).

If yes, when was such investigation conducted and at which institution? What was the outcome? (Please use a separate sheet to explain)

Name:_____
Last Name First Name Middle Initial

LIABILITY CLAIMS INFORMATION – FOR PAID FULL-TIME AND PAID PART-TIME CLINICAL FACULTY ONLY

Please document your professional liability loss experience for the most recent five-year period by attaching documentation prepared by your previous insurance carrier(s) and/or your prior employer(s). The documentation should include the following information:

1. Whether or not any professional liability claims or law suits were brought against you in the past five years.
2. Any settlements made on your behalf and/or judgments entered against you within the past five years.
3. A description of the material facts applicable to the claims and suits references in points one (1) and two (2), as well as the amount of any settlements/judgements made on your behalf.

Note: You may be requested to provide additional information regarding claims or suits resulting in settlements or judgments, including relevant records or descriptive information which may be available from your defense counsel or insurer.

APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION

I understand and agree that, as a candidate for a faculty appointment to CMSRU, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.

I authorize CMSRU and its agents to consult with employers, educational institutions, members of hospital medical staffs, professional liability carriers and any other persons or entities to obtain information about me, and I authorize any and all such persons and entities to release any information about me that may be relevant to any evaluation of my qualifications. This information may include confidential or privileged information, such as information about disciplinary actions and National Practitioner Data Bank (NPDB) reports. I hereby release CMSRU, its affiliated entities, employees and agents from any liability for requesting information and acting based on such information. I also release from liability any individuals and entities that in good faith provide such information to CMSRU.

I understand that any mistreatment or omission in this form may constitute grounds for denial of this appointment, discipline or termination. I agree that if any material changed occur affecting my professional status or qualifications or id I am notified by the National Practitioner Data Bank or any adverse action against me, or if I am convicted or plead guilty or no contest to any felony or misdemeanor, it is my obligation for immediately notify CMSRU.

I certify that the information provided on or with this form is try and complete to the best of my knowledge. I certify that I have fully read and understand the above statements and agree with them.

Applicant Signature:_____ **Date:**_____
(Signature stamp not accepted)