Intermountain Health

Cohort/Class #10: July 2024-June 2025

Application Deadline: Tues, 2/27 at 5 pm PST

Advanced Practice Provider Primary Care Fellowship Program Application

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Home Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Mobile Number: _____ Email: _____

Date of Birth: _____ Place of Birth: _____

Languages Spoken (other than English): _____

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

Have you ever been convicted of a crime? YES ◯ NO ◯

If yes, explain: _____

Education

Baccalaureate School Name: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ◯ NO ◯ Degree: _____

Post-Graduate School Name: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ◯ NO ◯ Degree: _____

Other Training: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ◯ NO ◯ Degree: _____

Other Training: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ◯ NO ◯ Degree: _____

Military Service

Branch: _____ From: _____ To: _____

Rank at Discharge: _____ Type of Discharge: Please select one

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

My application has been filled out accurately, to the best of my knowledge. I have read, understand, and agree with the information provided herein.

Applications must include:

- Signed application with all fields completed
- Photo/headshot appropriate for a professional application
- Curriculum Vitae / Resume
- Letter of recommendation from two categories: 1) Work Supervisor/Manager; 2) Clinical Preceptor; 3) Educator/Professor
- Letter of Good Standing from school or copy of grade transcript
- Personal statement

Applications, and required attachments, must be submitted via email by **5 pm PST on Tues, 2/27/24** to: APPfellowship@imail.org.
Applications will not be accepted after this deadline. Incomplete applications will not be considered.

For the complete application timeline and information about the program, please visit: https://intermountainNV.org/fellowships. Please direct questions to our program coordinator at: APPfellowship@imail.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 Healthcare's APP Primary Care Fellowship Program.

Applicant Signature: _____ Date: _____

Are you a former or current Intermountain Healthcare (or affiliate) employee? Yes ◯ No ◯

Office Use Only

Date/Time Received by Program Coordinator: _____