

Advanced Practice Provider  
**URGENT CARE**  
Fellowship Program Application



**Cohort 2 - Start Date: July 8, 2024**

Application Deadline: 5 pm on April 1, 2024

**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

YES NO

Have you ever been convicted of a crime?

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

**Education**

Baccalaureate School: \_\_\_\_\_ Address: \_\_\_\_\_

YES NO

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

Post-Graduate School: \_\_\_\_\_ 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

*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
- Two letters of recommendation from these categories: 1) Supervisor/Manager; 2) Preceptor; 3) Educator/Professor
- Letter of Good Standing from school (*regardless of whether you've graduated*)
- Personal statement

Applications, and required attachments, must be submitted via email by **5 pm on April 1, 2024** to: APPfellowship@imail.org. Applications will not be accepted after this deadline. Incomplete applications will not be considered.

Please direct questions to our program coordinator at: APPfellowship@imail.org.

Disclosure: After completing the 12-month program, fellows will transition to full providers 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 Urgent 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: \_\_\_\_\_