Office of Academic Appointments

Jack and Pearl Resnick Campus
1300 Morris Park Avenue, Belfer Room 902
Bronx, NY 10461
Phone: 718.430.2844 / Fax: 718.430.8770
www.einsteinmed.edu/oaa
academicappointments@einsteinmed.edu

FACULTY APPOINTMENT APPLICATION

Personal Data

First Name:	Middle:	Last Name:	
Gender: ☐ Male ☐ Female Suffix:	Country of Citizenship:		Country of Birth:
Street:			Apartment #:
City:	State:		Zip Code:
Country:	Email:		
Telephone :	Self Identification (optional):		

Office Address

Institution:			
Street Address:	Building:		Room #:
City:	State:		Zip Code:
Country:	Email:		
Telephone:	Fax:		

Have you received and reviewed the departmental criteria for Einstein faculty appointments? (clinical departments only) ☐ Yes ☐ No
Are you currently holding a full time faculty appointment at another medical school that you plan to maintain while faculty at Einstein? ☐ Yes ☐ No
If so, please indicate medical school:
Title: Date of Appointment:

Professional Interests

Please provide a brief description of your major area(s) of professional research interest and/or clinical area(s) of expertise. This information will be included on your webpage on the Einstein Faculty Directory. After your appointment is finalized, you will receive an email which will instruct you on how to update your webpage on the Einstein Faculty Directory.

American Board Certification Information

Primary Board Certification:	
Certification Year:	Re-Certification Year:

Primary Board Certification:	
Certification Year:	Re-Certification Year:

Primary Board Certification:	
Certification Year:	Re-Certification Year:

Education (List by highest degree first)

Degree:		Date Awarded:	
Medical School:			
Address:	State:	Zip:	Country:

Degree:		Date Awarded:	
Graduate School:			
Address:	State:	Zip:	Country:

Degree:		Date Awarded:	
Undergraduate/Other School:			
Address:	State:	Zip:	Country:

Affiliated Hospital Appointments

Hospital:	
Title:	Start Date:

Hospital:	
Title:	Start Date:

Hospital:	
Title:	Start Date:

Health Status

Are you able to perform the essential functions of the appointment as described to you, with or without accommodation? ☐ Yes ☐ No

Professional Liability Insurance

Present Insurance Company:		
Limits of Coverage:	Policy #:	
Period of Coverage:	Type of Coverage:	
Specialty Classification (eg. General Surgery, Ob/Gyn):	Excess Liability Coverage: ☐ Yes ☐ No	
Hospital Providing Excess Liability Coverage:		
Company Providing Excess Liability Coverage:		
Please indicate all other insurance companies / organizations that have provided liability insurance coverage to you during the last ten years:		
Name of insurance company:	Dates of coverage:	
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Name of insurance company:	Dates of coverage:	

Malpractice Activity

☐ Yes ☐ No	Are there any malpractice actions pending against you in this state or any other state?
☐ Yes ☐ No	Have any judgements in a malpractice action been entered against you in this state or any other state?
☐ Yes ☐ No	Have you entered into a settlement of any malpractice action brought against you in this state of any other state?
If you answered yes to any of the Malpractice Activity questions, please provide a full explanation:	

Professional Sanctions/Disciplinary Actions

Have you ever been found to have committed (or are charges now pending that could lead to a finding that you committed) any of the following:

☐ Yes ☐ No Professional Misconduct? | ☐ Yes ☐ No Scientific Misconduct? | ☐ Yes ☐ No Conflict of Interest?

Have you ever been found to have committed (or are charges currently pending against you that could lead to finding that you committed) a discriminatory act or violation of disciplinary rules that in any way related to your past or current professional activities? ☐ Yes ☐ No

Have you ever resigned from any academic institution or health care facility in order to avoid the impositions of disciplinary measures or curtailment of privileges in any way? ☐ Yes ☐ No

Have you ever been convicted of a crime other than a motor vehicle violation, juvenile offense or matter sealed by court? ☐ Yes ☐ No

If you are a PHYSICIAN, DENTIST, PSYCHOLOGIST, or other LICENSED HEALTH PROFESSIONAL, please answer the following:

Has there ever been imposed on you, or are you currently subject to, proceedings that could lead to a denial, revocation, suspension, reduction, limitation, probation, non renewal, or involuntary relinquishment or diminution of any of the following:

☐ Yes ☐ No Medical or other professional license/registration in any state?

☐ Yes ☐ No DEA/Controlled substance registration?

☐ Yes ☐ No Membership on any hospital or health care facility medical staff?

☐ Yes ☐ No Clinical privileges at any medical facility?

☐ Yes ☐ No Professional society membership, fellowship, or board certification?

☐ Yes ☐ No Internship, residency, other institutional affiliation or status?

☐ Yes ☐ No Participation in any reimbursement program?

If you have answered YES to any of the preceding questions please attach specifics on a separate piece of paper.

Failure to provide full and truthful answers is a continuing basis to invalidate this or any subsequent faculty appointment at any time.

Signature _____ Date _____

Please send completed and signed application form along with the documents listed below to the academic chair's office:

1. A copy of your current curriculum vitae and bibliography.
2. A copy of your current New York State Medical License Registration (if applicable).
3. A copy of your American Board Cerification Certificate(s) (if applicable).
4. A copy of your Doctoral Degree(s).
5. A copy of your letter of resignation to any other medical school at which you may have a current appointment (other than visiting or adjunct status).
6. A completed and signed Authorization to Release Information Form.
7. A copy of your completed COI Form.
8. If you are a clinician, two letters of reference regarding your professional competence, moral character and conformity to professional ethical practices. Preferably, these letters should be from chairs, chiefs of staff, or directors of hospital services from facilities in which you have held an appointment.
9. A copy of the email confirmation you receive after submitting your COI disclosure is required to be submitted with this application for your faculty appointment to be finalized.

Please contact the COI Office at COI@einsteinmed.edu to establish your account to access the COI disclosure system. For those on the Einstein or Montefiore payroll, you will need your AD credentials before you can submit your COI disclosure.

After submitting your COI disclosure, you will receive an email confirmation, which may be used for your faculty appointment application.

For general COI information please use the following link: https://www.einsteinmed.edu/administration/conflict-of-interest/