Carolinas Rehabilitation

ORTHOPAEDIC PHYSICAL THERAPY CLINICAL RESIDENCY PROGRAM APPLICATION

(Please print legibly)

Resident Applicant Profile

Name _____Date _____

Home Address _____ City _____

State _____ Zip _____Phone No. _____ FAX No. _____

Home email address _____

Work Address _____ City _____

State _____ Zip _____ Phone No. _____ FAX No. _____

Work email address _____

APTA membership number_____

Emergency Contact _____ Emergency Phone No. _____

Professional License Detail

State:	License Type:	License No.	Issue Date:	Expiration Date:
State:	License Type:	License No.	Issue Date:	Expiration Date:
State:	License Type:	License No.	Issue Date:	Expiration Date:

Board Certification Detail

Issuing Board	Certification Credential	Certificate No.	Issue Date	Expiration Date

Please list the issuing organization and expiration date or you current CPR certification _____

Employment Status

Date of Hire	Employment Description: ☐ Full Time ☐ Part Time ☐ Pool or PRN
Current Job Title	

Do you require any special accommodations to ensure a satisfactory learning experience? ☐ yes ☐ no If yes, please detail.

_____

_____

_____

Educational Background

INSTITUTION	DEGREE	DATE of COMPLETION

Summary of School/Work Experience and Clinical Expertise: *(briefly describe your work experience in terms of number of years or direct patient practice and in what setting with what type of patients; Also, please indicate the type of patients, pathologies, or services with which you have the most comfort)* – use additional paper as necessary

External Continuing Education Courses Completed: (*use separate sheet of paper if necessary)*

COURSE	CEU Credit	DATE ATTENDED
1.		
2.		
3.		
4.		
5.		
6.		

RESIDENCY GOALS: *please briefly describe your goals for this program and your future professional plans:*

Please outline the reasons you feel your application should be accepted for participation in this program.

Checklist: *Please ensure that each of the following items accompanies your application. The application will not be processed until all of these documents are submitted.*

- ✓ Copy of professional practice license(s) with expiration date.
- ✓ Three letters of endorsement (these letters should be from licensed health care providers with at least one from a person who was your supervisor or clinical instructor). Recommendations from physical therapists will be most strongly considered. These letters of endorsement may be submitted separate for this application but sent to the same address as below.
- ✓ Current curriculum vitae or professional resume.
- ✓ CPR certification card with expiration date.

It is the applicant's responsibility to submit <u>three complete copies</u> of the entire application and its surrounding documentation.

Upon completion, this application should be sent to Jenny Trull, Administrative Assistant at Carolinas Rehabilitation; 1100 Blythe Blvd. Charlotte, NC 28203

_____

Signatures:

_____ _____

Applicant *Date*

ATTESTATION QUESTIONS

Please answer the following questions "Yes" or "No". **<u>If you answer to any of the questions is "Yes", please provide complete details on a separate sheet.</u>**

	QUESTION	YES	NO
1.	Has your license to practice medicine in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, or subject to probationary conditions, or have you been fined or received a letter of reprimand – or is such action pending?		
2.	Has your Drug Enforcement Administration (DEA) certification or an applicable narcotic certification ever been restricted, limited, suspended, revoked, not renewed, or subject to probationary conditions, or have you been fined or received a letter of reprimand, or are such actions pending with respect to your DEA certification? If applicable.		
3.	Have your hospital privileges at or with a healthcare organization (e.g. medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payor, medical society, professional association, medical school facility position or other health delivery entity or system) ever been denied, restricted, limited, suspended, revoked, not renewed; have a disciplinary proceedings ever been instituted against you; or are any of these actions now pending? If applicable.		
4.	Have you ever surrendered clinical privileges, terminated contractual participation or employment, or resigned from any medical/healthcare organization (e.g medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payor, medical society, professional association, medical school facility position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or in return for such an investigation not being conducted, or is any such action pending?		
5.	Has your participation in Medicare, Medicaid, or other government program ever been denied, limited, suspended, revoked, not renewed, or subject to probationary conditions; or, to the best of your knowledge, have you ever been under investigation by a regulatory agency?		
6.	Have you ever been convicted of a felony or do you have any felony or misdemeanor charges pending other than traffic offenses; or history of crimes against children?		
7.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization even revoked, denied, limited, or not renewed, or is any such action pending?		
8.	Have you ever been denied certification/recertification, or has your eligibility status changed with respect to certification/recertification by a specialty or governing board?		
	HEALTH STATUS		
9.	Are you **<u>unable</u>** to perform all of the professional services for which you have been licensed with or without reasonable accommodation, according to all accepted standards of professional performance and without posing a direct threat to your safety or the safety of patients?		
10.	Do you now have, or have you had, a chemical dependency or any mental health problem(s) or are you currently receiving professional care for substance abuse or any similar treatment?		
11.	Are you currently taking any medications that may affect either your clinical judgment or motor skills?		
12.	Are you using drugs illegally?		

Practitioners Signature: _____ Date: _____
(STAMPED SIGNATURE IS NOT ACCEPTED)

Printed Name: _____