The HCA Healthcare Resident/Fellow Stipend Program

APPLICATION MATERIALS:

All of the following are required materials for the Stipend application. Please use a check mark to indicate completion. Upon thorough completion of all application materials, please compile together in the order listed below and fax to (866) 897-4078 or email to Christian.McFall@HCAHealthcare.com. If submitting by email, PDF versions of the required documents are preferred.

- ☐ **Contact Information and Medical Training History Form (p.2)**
- ☐ **Disclosure Questions & Attestations Signature (p. 3)**
- ☐ **Letter of Recommendation (p.4)**
- ☐ **Personal Vision Statement (p.5)**
- ☐ **Curriculum Vitae (p.6)**

Please Note: Your application will be processed according to the timeline below. Upon submission you may receive an introductory phone call from an HCA Healthcare representative to discuss or clarify items on your application.

January 1 - March 1, 2020	Applications received for 1Q review period
March 1, 2020	**1Q Deadline for Applications**
March 25, 2020	Candidates are notified of their status
March 2 - June 1, 2020	Applications received for 2Q review period
June 1, 2020	**2Q Deadline for Applications**
June 25, 2020	Candidates are notified of their status
June 2 - September 1, 2020	Applications received for 3Q review period
September 1, 2020	**3Q Deadline for Applications**
September 25, 2020	Candidates are notified of their status
September 2 - December 1, 2020	Applications received for 4Q review period
December 1, 2020	**4Q Deadline for Applications**
December 28, 2020	Candidates are notified of their status

Contact Information & Medical Training History

Contact Information

Legal Name	Date of Birth	Gender
Current Mailing Street Address, Apt or Suite #	Email address	
City, State Zip	Current Home Phone #	Social Security #
Hometown/Location	Medical License # and State Issued	NPI #

Education & Training

Medical School

Start Month - Year	End Month Day Year	Name
Specialty		City, State

Residency

Start Month - Year	End Month Day Year	Name
Specialty		City, State

Fellowship 1

Start Month - Year	End Month Day Year	Name
Specialty		City, State

Fellowship 2 (if applicable)

Start Month - Year	End Month Day Year	Name
Specialty		City, State

Geographic Preferences

☐ Alaska	☐ Florida	☐ Indiana	☐ Louisiana	☐ Nevada	☐ South Carolina	☐ Utah
☐ California	☐ Georgia	☐ Kansas	☐ Mississippi	☐ New Hamp.	☐ Tennessee	☐ Virginia
☐ Colorado	☐ Idaho	☐ Kentucky	☐ Missouri	☐ North Carolina	☐ Texas	

If you plan on doing additional training, please indicate dates below:

Start Month/Year	**Anticipated Finish** Month/Year	**Specialty**

Please disclose any immediate family members who are on medical staff of an HCA Healthcare affiliated facility

Name	**Facility**	☐ **Not Applicable**

How did you hear about the Stipend Program?

Event Type	**Name of Person**	**Other**

USMLE Scores			**Comlex Scores**		
STEP 1 Score & Date	**STEP 2 Score & Date**	**STEP 3 Score & Date**	**Level 1 Score & Date**	**Level 2 Score & Date**	**Level 3 Score & Date**

Please Check One: ☐ US Citizen ☐ H1B ☐ J1 ☐ Green Card ☐ H1B Exempt

DISCLOSURE QUESTIONS

1. ☐ Yes ☐ No — Has your **professional license or registration** ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished, or not renewed by any licensing board of any health-related agency or organization, or is there a review pending?

2. ☐ Yes ☐ No — Has your **DEA registration** ever been revoked, suspended, limited, or conditioned in any way, or have you ever voluntarily relinquished your DEA registration, or is there a review pending?

3. ☐ Yes ☐ No — Has your **membership, participation, clinical privileges, or employment** ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?

4. ☐ Yes ☐ No — Have you ever voluntarily or involuntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license, or registration as an alternative to disciplinary action, or prior to or during an investigation into your professional conduct or competence?

5. ☐ Yes ☐ No — Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any **licensing board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization**?

6. ☐ Yes ☐ No — Has your certificate or participation in any **private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?

7. ☐ Yes ☐ No — Are there any **charges pending or are you currently charged with** or have you ever been indicted or found guilty of felony, misdemeanor (other than a minor traffic violation), **or other offense involving** fraud, misrepresentation, dishonesty or deceit?

8. ☐ Yes ☐ No — Have you ever been the **subject or target of a sexual harassment complaint** or investigation or other complaint or investigation involving sexual misconduct or impropriety?

9. ☐ Yes ☐ No — Have you ever had any **professional liability claims or lawsuits** brought against you, including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments? **If yes, please complete the enclosed Professional Liability Addendum. You may be asked for additional information by individual organizations.**

10. ☐ Yes ☐ No — Has your **professional liability carrier** ever refused or canceled your coverage?

11. ☐ Yes ☐ No — **Have you ever been convicted of using illegal drugs?**

12. ☐ Yes ☐ No — **Have you ever been convicted of driving under the influence?**

13. ☐ Yes ☐ No — **Do you have any reason to believe that you may not be able to obtain hospital privileges?**

If you answered yes to any of the questions above, please attach a signed and dated written explanation.

Please read the following two questions carefully.

14. ☐ Yes ☐ No — **Do you have permanent legal authorization to work in the United States?** If no, please indicate your current work status: _____

15. ☐ Yes ☐ No — **Are you currently on staff at any HCA Healthcare hospital?** If so, where? _____

Attestation Signature and Date

I hereby certify that all the information form is complete, true and accurate

Electronic Signature: _____ Date: _____

Letter of Recommendation

Every physician who applies for the HCA Healthcare Resident/ Fellow Stipend Program must submit a formal letter of recommendation from someone at your current training program.

All letters must be typed on official program letterhead and include:

- **The date you started your training**
- **The anticipated date you will complete your training**
- **The author's signature**

The letter should be from a Program Director/Department Chair (or other faculty member) who knows you well enough to comment in depth on not only your academic performance, but also your personal qualities and their impact on your future career in medicine. Both items - your professional performance and your personal qualities - are equally important.

Letters should included information on how long the Program Director/Department Chair (or other faculty member) has known you and in what capacity, and how well they know you. They should also put their remarks about you into some kind of comparative context with other physicians they have supervised or for whom they have written letters.

Things such as work ethic, clinical competency, and surgical skills (if applicable) should also be included.

Along with the other pieces of the application packet, your letter of recommendation will be reviewed by a committee of HCA Healthcare leaders and carries significant weight in the stipend award process.

Vision Statement

Your vision statement should be a typed document which provides a detailed description of your professional and personal goals upon completion of your training.

Detailed information on why you chose a career in medicine, how you chose your medical specialty, what you hope to accomplish once you begin medical practice, personal/ professional achievements that have impacted your personal/ professional development, life experiences that have impacted your personal/professional development, and other related topics are all recommended for inclusion in your vision statement.

The HCA Healthcare Resident/Fellow Stipend Program is highly competitive with a strong group of applicants each quarter. A screening committee of HCA Healthcare leaders reviews each application and your vision statement will be reviewed in depth as a part of the committee's stipend selection process.