The HCA/HCA PSG *Earn While You Learn* Resident/Fellow Stipend Program

APPLICATION MATERIALS:

All of the following are requested 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 Daniel.Christian@HCAHealthcare.com.

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

- ☐ **Contact Information and Medical Training History Form (p.2)**
- ☐ **Disclosure Questions & Attestations Signature (pp. 3-4)**
- ☐ **Letter of Recommendation (p.5)**
- ☐ **Personal Vision Statement (p.6)**
- ☐ **Curriculum Vitae (p.7)**

January 1 - March 1, 2017	Applications received for 1Q review period
March 1, 2017	**1Q Deadline for Applications**
March 20, 2017	Candidates are notified of their status
March 2 - June 1, 2017	Applications received for 2Q review period
June 1, 2017	**2Q Deadline for Applications**
June 20, 2017	Candidates are notified of their status
June 2 - September 1, 2017	Applications received for 3Q review period
September 1, 2017	**3Q Deadline for Applications**
September 20, 2017	Candidates are notified of their status
September 2 - December 1, 2017	Applications received for 4Q review period
December 1, 2017	**4Q Deadline for Applications**
December 20, 2017	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	☐ S. Carolina	☐ Utah
☐ California	☐ Georgia	☐ Kansas	☐ Mississippi	☐ New Hamp.	☐ Tennessee	☐ Virginia
☐ Colorado	☐ Idaho	☐ Kentucky	☐ Missouri		☐ 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 HCAPS 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

HCA
Hospital Corporation of America℠

Disclosure Questions

Please provide a **complete, signed and dated** explanation on a separate sheet if any of questions 1 – 13 are answered Yes.

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 a 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?**

Additional Questions

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

Yes ☐ No ☐ Are you currently on staff at any HCA hospital? Is so, where: _____

Attestation Signature and Date

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

Electronic Signature: _____ Date: _____

Professional Liability Addendum

If you answered yes to disclosure question #9, please provide the following detailed information for each malpractice claim brought against you, including pending claims, lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments. (Please make additional copies of this page if needed.)

Claim #1

Date of Occurrence	Amount paid/in reserve to resolve claim	Institution Involved (i.e. hospital, etc)
Name of Insurance Carrier		
Insurance Carrier Address/City/State/Zip		
Current Status of Claim (open/closed/pending/resolved, etc.)		Date Closed
Details of Allegations		

Claim #2

Date of Occurrence	Amount paid/in reserve to resolve claim	Institution Involved (i.e. hospital, etc)
Name of Insurance Carrier		
Insurance Carrier Address/City/State/Zip		
Current Status of Claim (open/closed/pending/resolved, etc.)		Date Closed
Details of Allegations		

Electronic Signature: _____ Date: _____

Letter of Recommendation

Every physician who applies for the HCA/HCA PSG "Earn While You Learn" Stipend must submit a formal letter of recommendation.

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 best letters are from Program Directors/Department Chairs (or other faculty members) who know you well enough to comment in some depth on not only your academic performance, but also your personal qualities and their impact on your future career in medicine. Both things are equally important. They should mention how long they have 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.

Vision Statement

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