Colorectal Surgical Oncology Fellowship Application

Please complete all sections and ensure all information is typed or printed legibly. Attach additional pages as necessary and include your name on each attached page. Optional demographic information may be collected by Moffitt Human Resources for institutional reporting; it is not used in candidate selection.

Section A – Applicant Information

1. Academic Year for which you are applying _____

2. Full Legal Name _____
   Last First MI Degree
3. Preferred Name_____

4. Date of Birth _____

5. Email Address_____

6. Cell Phone_____

7. Current Mailing Address_____

8. Permanent Mailing Address (If different)

_____

9. Are you authorized to work in the United States without visa sponsorship?
   Yes _____ No_____

10. If yes, please note basis (Citizen/Permanent Resident) _____

Section B – Identifiers and Licensure

11. National Provider ID (NPI)_____

12. Federal DEA Registration Number (if held)_____

13. DEA Issue/Expiration Date_____

14. Do you currently hold an active, unrestricted medical license in any US state?

Yes_____ No _____

15. Do you hold, or are you eligible for, a full unrestricted Florida medical license?

Yes_____ No_____

16. Please list all medical licenses held

(State)	(License #)	(Date Issued/Exp)	(Active or Inactive?)
(State)	(License #)	(Date Issued/Exp)	(Active or Inactive?)
(State)	(License #)	(Date Issued/Exp)	(Active or Inactive?)

Section C – Board Certification

17. Please list all board certifications.

(Board Name)	(Status - Certified/Eligible)	(Date Certified)	(Recertification Date)
(Board Name)	(Status - Certified/Eligible)	(Date Certified)	(Recertification Date)
(Board Name)	(Status - Certified/Eligible)	(Date Certified)	(Recertification Date)

Section D – Examinations

18. Please list all examinations and attach official transcripts

USMLE Step 1		USMLE Step 2				USMLE Step 3	
(Date Passed)	(Score)	(CK Date Passed)	(Score)	(CS Date Passed)	(Score)	(Date Passed)	(Score)

For graduates of international medical schools, are you ECFMG certified? Yes_____ No_____	
ECFMG Certificate Number	Date ECFMG Certification Granted

COMLEX Level 1		COMLEX Level 2		COMLEX Level 3	
(Date Passed)	(Score)	(Date Passed)	(Score)	(Date Passed)	(Score)

Section E – Medical Education

19. Please spell out institution names; do not abbreviate. Attach additional pages if needed.

(Mo/Yr) (Mo/Yr) **to**	(Undergraduate)	(City/State/Country)	(Degree)
(Mo/Yr) (Mo/Yr) **to**	(Graduate School, if applicable)	(City/State/Country)	(Degree)
(Mo/Yr) (Mo/Yr) **to**	(Medica School)	(City/State/Country)	(Degree)
(Mo/Yr) (Mo/Yr) **to**	(Other)	(City/State/Country)	(Degree)
(Mo/Yr) (Mo/Yr) **to**	(Other)	(City/State/Country)	(Degree)

Section F – Graduate Medical Education

20. Please list all internships, residencies, and fellowships consecutively from medical school graduation. Include every position held or program enrolled in, even if brief or not completed. All time periods must be accounted for.

(Mo/Yr) (Mo/Yr)	(Position)	(Specialty)	(Institution)	(City/State/Country)
to				
(Mo/Yr) (Mo/Yr)	(Position)	(Specialty)	(Institution)	(City/State/Country)
to				
(Mo/Yr) (Mo/Yr)	(Position)	(Specialty)	(Institution)	(City/State/Country)
to				
(Mo/Yr) (Mo/Yr)	(Position)	(Specialty)	(Institution)	(City/State/Country)
to				

Section G – Other Employment, Activities, and Gaps

21. Please list all other employment or activities since medical school graduation. All gaps in training or employment must be explained, including time spent preparing for examinations.

(Mo/Yr) (Mo/Yr)	(Activity/Position)	(Institution, if applicable)	(City/State/Country)
to			
(Mo/Yr) (Mo/Yr)	(Activity/Position)	(Institution, if applicable)	(City/State/Country)
to			
(Mo/Yr) (Mo/Yr)	(Activity/Position)	(Institution, if applicable)	(City/State/Country)
to			

Section H – Professional Background Disclosures

If you answer "Yes" to any question below, please attach a full written explanation.

22. Have you ever had disciplinary or remedial action taken against you, or an investigation initiated, by any state or regulatory agency, administrative body, licensing board, or professional organization in connection with your practice of medicine or participation in a training program (including any currently pending)? Yes_____ No_____

23. Have you ever been named as a party in, or served as a witness in, any medical malpractice action? Yes_____ No_____

24. Do you have any medical malpractice action currently pending against you? Yes_____ No_____

25. Have you ever been convicted of an act constituting a crime, including DUI/DWI or any criminal misdemeanor? Yes_____ No_____

26. Have you ever voluntarily or involuntarily relinquished, or had limited, your medical license, registration, or certification — including during an investigation or under threat of proceedings? Yes_____ No_____

27. Have you ever agreed to, or had imposed, a limitation or reduction of your clinical privileges at any hospital, health care facility, or training program? Yes_____ No_____

28. Have you ever left, resigned from, been terminated from, or been disciplined in a position because of inadequate performance, unprofessional conduct, or disruptive or violent behavior? Yes_____ No_____

29. Do you have any conditions for which you are not receiving appropriate treatment that would impair your ability to practice medicine with reasonable skill and safety? Yes_____ No_____

Section I – Professional References

30. Please list three individuals providing letters of recommendation. At least one must be your department chair or division head. Letters of reference must be sent directly to the Program Administrator from the letter writers.

Name/Degree	Title/Position	Institution	Email Address	Relationship to You

Section J – Personal Statement Summary

31. Please briefly summarize your career goals and desired curriculum focus (the full one-page Personal Statement should be attached separately).

Section K – Attestation, Authorization, and Signature

Moffitt Cancer Center is an equal opportunity employer. All qualified applicants receive consideration without regard to any characteristic protected by applicable law. Moffitt Cancer Center is a tobacco-free institution.

32. I certify that the information contained in this application and all attachments is true, correct, and complete to the best of my knowledge and belief. I understand that omission or misrepresentation of any fact called for in this application or during the appointment process is grounds for rejection of this application or for dismissal after appointment. I authorize Moffitt Cancer Center to verify all information provided, and I authorize any hospital, educational institution, health care facility, licensing board, or individual with whom I have had an educational, professional, or employment affiliation to release to Moffitt Cancer Center any information requested in connection with this application. I release Moffitt Cancer Center, its trustees, officers, agents, and employees, and all other individuals and entities, from civil liability relating to the good-faith gathering, review, and verification of such information. I understand that appointment is contingent upon successful completion of Moffitt's onboarding requirements, including credentialing, background check, occupational health clearance, drug screening, and verification of an active, unrestricted Florida medical license prior to the start date. I acknowledge my responsibility to promptly update this application in writing to the Program Director if any information changes prior to or during my appointment. I understand that this is a non-ACGME-accredited institutional fellowship and that its completion does not confer eligibility for a new specialty board certification.

Signature_____

Printed Name _____ **Date:** _____