PLEASE PRINT OR TYPE

OU-COM/CORE FACULTY PROFILE

Date_________________

Name____Degree__________Gender________________
First Middle Initial Last Jr./Sr.

Specialty____ DOB_________________________

AOA/AMA #____
(for CME purposes)

If board certified, name of board:____

Please list below where the student will spend 50% or more of his/her training time:

Business Name: ____inpatient_______ outpatient________
(check one)

Business Address (no P.O.)

____
Street City State Zip County

Business Phone__________________________ E-mail Address____
Area Code Phone number

Mailing address if different:

____
Street City State Zip County

Professional liability insurance ☐ yes ☐ no Name of Insurance Company____

Amount of Malpractice coverage ________________________ per occurrence ____________________________aggregate
(May attach copy of malpractice face sheet)

Home address

____
Street City State Zip County

Specify Type of Practice: (Check all that apply)

____Solo, Private Practice
____Group, Private Practice
____In a medically underserved community
____In a health professional shortage
____Federally Qualified Health Center
____Rural Heath Center
____Hospital
____Office

Indicate Percentages of Practice:

_____ % Medicaid
_____ % Medicare
_____ % Private/Commercial
_____ % Charity
_____ % Other____________________

County of the Practice Location:_________________
(Check one of the items below)

____ Non-metro county with urban population of 2,500-19,999, adjacent to a metro area (Rural)
____ Non-metro county with urban population of 20,000 or more, adjacent to a metro area (Small town)
____ County in metro area of fewer than 250,000 population (Small Metro)
____ County in metro area of 250,000 to 1 million population (Metro)
____ County in metro area with 1 million population or more (Large Metro)

Specify Patient/Client Volume:

____ < 25/day ____ 50-75/day
____ 25-50/day ____ > 75/day

Ethnicity (optional): ____ White (non-Hispanic) ______ Native American
____ Hispanic _____ Asian/Pacific Islander
____ Black _____ Other (please specify) _____________

PLEASE PRINT OR TYPE

Name/Title

____

List name and contact information (i.e., phone, fax, e-mail) of anyone other than yourself who should be notified of a student's rotation (e.g. Med. Ed. Dept.)

____
____
____
____

EDUCATION (may attach current CV)

Medical Colleges/Graduate school	Name of Institution	Date
Type of Internship completed	Name of Institution	Date
Type of Residency completed	Name of Institution	Date
Type of Residency completed	Name of Institution	Date
Type of Post-residency Training completed (e.g., Fellowships, etc.)	Name of Institution	Date
Type of Post-residency Training completed (e.g., Fellowships, etc.)	Name of Institution	Date

HOSPITAL AFFILIATIONS (active, consulting, courtesy, other):

Hospital Membership	Active	Consulting	Courtesy	Other

CURRENT AND PAST TEACHING APPOINTMENTS: (may attach current CV)

____
____
____
____
____

LEADERSHIP POSITIONS: (may attach current CV)

____
____
____
____

PAPERS/WRITINGS/PUBLICATIONS: (may attach current CV)

____
____
____

PLEASE PRINT OR TYPE

Name/Title ____

PRESENTATIONS: (may attach current CV)

____
____
____

Other Scholarly projects (i.e. test writer, curriculum development, policy and procedure): (may attach current CV)

____
____
____

RESEARCH INTEREST:

____
____
____
____

Have you had your research or an article published? yes _____ no _____

REFERENCES: (may attach current CV)

List three (3) professional references:

Name	**Phone**
_____________________________________	________________________
_____________________________________	________________________
_____________________________________	________________________

Please list other physicians/practitioners affiliated with your practice who teach OU-COM students:

____

Name	**Degree**	**AOA/AMA # for CME purposes**

____

Name	**Degree**	**AOA/AMA # for CME purposes**

____

Name	**Degree**	**AOA/AMA # for CME purposes**

Will you share CME Hours earned on this service with other physicians/practitioners? Yes _____ No _____

If yes, what percentage will you split/share? _______________

May OU-COM share this information with other Colleges of Osteopathic Medicine for their appointment process?
yes _____ no _____

Please indicate if your current faculty status/appointment allows you to hold an OU-COM/CORE Group IV appointment **yes _____ no _____**

PLEASE PRINT OR TYPE

OHIO UNIVERSITY
College of Osteopathic Medicine

DISCLOSURE

Please answer the following questions "yes" or "no". If your answer to questions 1-18 is "yes" or if your answer to question 19 is "no", please provide **a written explanation** on a separate sheet.

INSTRUCTION NOTE: A voluntary surrender or non-renewal is for reasons related to professional competence or conduct when the surrender or non-renewal is done to avoid an adverse action, preclude an investigation or is done while the licensee is under investigation related to professional competence or conduct.

		Yes	No
1.	Have any of your board certifications or equivalents ever been suspended, revoked, voluntarily surrendered or have you failed to recertify?		
2.	Has your professional license, in any jurisdiction, ever been voluntarily or involuntarily suspended, limited, revoked, denied, or surrendered or subjected to probationary conditions or are any such actions pending?		
3.	Has your DEA license or state narcotics registration ever been voluntarily or involuntarily suspended, limited, revoked, denied, or restricted for reasons other than non-completion of medical records or are any such actions pending?		
4.	Has your hospital or facility medical staff membership or have your hospital or facility professional privileges ever been voluntarily or involuntarily suspended, limited, revoked, denied or surrendered for reasons related to professional competence or conduct, other than non-completion of medical records or are any such actions pending?		
5.	Have you ever been placed on probation or asked to resign an internship or residency-training program?		
6.	Has Medicare, Medicaid, or any other medical reimbursement plan ever voluntarily or involuntarily suspended, limited, revoked, denied, not renewed or terminated your participation for reasons related to professional competence or conduct?		
7.	Have you ever been or are you currently excluded from participation with Medicare or any other federally funded health care program?		
8.	Has your professional liability coverage ever been restricted, limited, denied, not renewed, or special rated (for reasons other than the carrier's termination of operations in your state)?		
9.	Have you ever been named as a defendant in any criminal case? (excluding minor traffic infractions, but not DUIs)		
10.	Have you ever been convicted of a felony?		
11.	Have you ever been disciplined for a violation of ethical standards by a professional organization?		
12.	To your knowledge has information pertaining to you ever been reported to the National Practitioner Data Bank?		
13.	Do you have a history of engaging in the illegal use of drugs? ("Illegal use of drugs" means the use of any controlled substances illegally obtained, i.e. not obtained pursuant to a valid prescription and not taken in accordance with the direction of a licensed health care practitioner.)		
14.	Are you currently engaged in the illegal use of drugs? ("Currently" does not mean on the day of or even the weeks preceding the completion of this OU-COM/CORE FACULTY PROFILE. Rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)		
15.	Are you currently in treatment for addiction to drugs or alcohol?		
16.	Within the last five years, have you been reprimanded or disciplined in any manner by any state licensing authority or other professional board for conduct related to the use of alcohol or the use of any drug?		
17.	Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic testing center, hospital, ambulatory surgery center, or other business dealing with the provision of ancillary health services, equipment, or supplies?		
18.	Do you have any emotional or physical disabilities that may limit your ability to practice?		
19.	Are you able to perform the procedures and the essential functions of the position for which you have applied or requested privileges, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients?		

I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief.

____

Signature of Applicant Date

____

Signature of CORE Assistant Dean reviewing profile Date

Please mail to your local CORE Office