



NEW YORK INSTITUTE OF TECHNOLOGY

College of Osteopathic
Medicine

Instructions for filing a NYIT College of Osteopathic Medicine Clinical Faculty Application.

The Clinical Faculty Application is an Adobe Acrobat fillable form. The [Adobe Acrobat Reader](#) (available with the full version of Adobe Acrobat or as a free download) is required. To complete the form on an iPad, install the Adobe Acrobat Reader app appropriate for your device, and open the form with the Reader app. If you are accessing the form through a URL, **download** the file to a computer or device, then complete the form with Acrobat Reader. **SAVE** the form to your computer or device. Proceed to Step #3.

1. Whether this is a first time application, or you have a previous appointment, please complete the appropriate sections of this application so we may update our records.
 - a. For Hospital Affiliated Clinical Faculty: Complete pages 1, 2, 4, 5 and 7.
 - b. For Office Preceptor Clinical Faculty: Complete ALL pages of the application.(Be certain to completely fill out the Preceptor Profile, page 3).
 - c. For both Hospital Affiliates and Office Preceptors, please complete the Self Identification Form, page 6.
2. Signatures required: three (3) pages must be signed by the requested “signatory”; sign the pages, scan, and send the document by email.
 - a. Attestation Page, page 4, signature of applicant.
 - b. Application Signature Page, page 5, signature of applicant.
 - c. Teaching Role Page, page 7, Signature of DME.
3. After **SAVING** your application on your computer/device, send the Completed, Typed Document as an attachment via **email** to: comfacappt@nyit.edu
OR Fax your document to **(516) 686-3840**.
*****Please Note: Handwritten applications may increase processing time.*****
4. Requested documentation may be scanned and emailed, or faxed to the number provided.
5. Questions should be directed to comfacappt@nyit.edu with the subject of **Question**.
6. **An acknowledgement of receipt of your application will be sent by email to your preferred email address. Please be certain your preferred email is contained within the application being submitted. If you do not receive an acknowledgement email within 4 business hours, please email comfacappt@nyit.edu to confirm receipt.**



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Clinical Faculty Application	
To initiate an academic appointment at the New York Institute of Technology College of Osteopathic Medicine, please complete and return the following items. You will be considered clinical faculty only upon receipt of a letter and certificate from NYITCOM indicating your appointment.	
	An updated copy of your curriculum vitae
	A copy of your medical school diploma
	A copy of your medical license and/or current medical registration
	A copy of your current Board Certification
	The signed Clinical Faculty Application
	The signed Teaching Role
Associate Dean, Academic Affairs Serota Building, Room 228 New York Institute of Technology College of Osteopathic Medicine Old Westbury, NY 11568	<i>Please Return Application Package to:</i> Fax: 516-686-3840 Email: comfacappt@nyit.edu

For Non-Licensed Residents	
To initiate an academic appointment at the New York Institute of Technology College of Osteopathic Medicine, please complete and return the following items. You will be considered clinical faculty only upon receipt of a letter and certificate from NYITCOM indicating your appointment.	
	An updated copy of your curriculum vitae (include your current residency)
	A copy of your medical school diploma
	Documentation showing that you are enrolled in a ACGME approved residency
	A signed letter from the program director of the department you will be working in indicating the licensed doctor supervising you
	The signed Clinical Faculty Application
	The Teaching Role Page signed by either the DME or department head
Associate Dean, Academic Affairs Serota Building, Room 228 New York Institute of Technology College of Osteopathic Medicine Old Westbury, NY 11568	<i>Please Return Application Package to:</i> Fax: 516-686-3840 Email: comfacappt@nyit.edu

**Clinical Faculty Application
Main Application Page**

Applicant Name (Last, First & MI):			
Applicant Street Address:			
Applicant City, ST, Zip:			
Applicant Preferred Email:		Applicant Cell Number:	
Applicant Gender:	Applicant DOB:	Applicant Medical Degree:	
Degree Granting Med. Institution (Include City and State):			Grad. Year:
Internship Hospital (NA if Not Applicable):		Location (City State):	Start Mo/Year: End Mo/Year:
Residency Hospital:		Location (City State):	Start Mo/Year: End Mo/Year:
Fellowship Hospital (NA if Not Applicable):		Location (City State):	Start Mo/Year: End Mo/Year:
Current Medical License (State, Year):	Practice Specialty:		
Board Certified:	Bd. Certified Current Specialties:	Recertification Year:	
Current (Other) Medical School Appointments (School, Rank):		Start Mo/Yr.:	End Mo/Yr.:
For HOSPITAL AFFILIATED CLINICAL FACULTY ONLY. Preceptors continue with Preceptor Profile, p 3. Current Hospital Name:		Hosp. Dept:	
Hospital Address: Street Address: City St Zip:		Hosp. Title/Position:	
Contact at Hospital:		Contact Title/Position:	
Contact Email:	Contact Phone:	Contact Fax:	

Clinical Faculty Application Preceptor Profile

Applicant Name (Last, First & MI):		Total Years in Practice:	Years in Present Practice:	
Office/Clinic Name:		Office Phone:	Office Fax:	
Office/Clinic Address:		Clinic Contact:	Contact Email:	
Practice is Solo/Group:	Number of Days/week in Office:	Hours/Day in Office:	Hours/week in Hospital	
Number Associates (if Group, otherwise NA):	Check 1) which of the following are a part of the Office Environment; 2) which is available as part of student training (answer all):	X-Ray	In office/clinic	Available to trainees
		Lab Tests	In office/clinic	Available to trainees
		EMR	In office/clinic	Available to trainees
Please identify the Specialties available in your practice by identifying the percent of cases seen within a month. Check all that apply. Scale: Significant = Greater than or equal to 10%; Minimal = Less than 10%; Not Applicable = Generally none.				
<u>Specialty</u>	<u>Significant</u>	<u>Minimal</u>	<u>Not Applicable</u>	<u>Comments</u>
Dermatology				
Emergency Medicine				
General Surgery				
Geriatrics				
Osteopathic Manipulative Treatment				
Orthopedics				
Obstetrics/Gynecology				
Nutrition/Wellness				
General Pediatrics				
Sports Medicine				
Internal Medicine				
Physical Medicine & Rehabilitation				
Psychiatry/Behavioral Medicine				
List predominant procedures performed in office:				
Comments:				

Clinical Faculty Application Attestation Page

1.	Has your license ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any reason?	
2.	Have you ever been subject to review, challenges, disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?	
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?	
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?	
5.	Have you ever been charged with, or have notice of anticipated charges of a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?	
6.	Do you have any pending malpractice incidents or have you had any arbitrated, mediated or litigated malpractice actions within the past 7 years?	
<p>If you answered “Yes” to any of the questions above, please provide a brief explanation here, or attach a separate page with signature and date.</p>		

I attest that all statements made on this form and on any attached documentation are complete, accurate and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of application, or faculty suspension/dismissal from New York Institute of Technology College of Osteopathic Medicine.

Applicant's
Signature: _____ Date: _____

My typed signature is my symbol and intent of authentication where I willingly sign, understand, and adopt this document.

Clinical Faculty Application Application Signature Page

I affirm that I am duly licensed to practice medicine, and have current medical malpractice insurance. I will notify the Associate Dean of Academic Affairs immediately of any changes to my practice status. I agree that either party will provide the other with at least a 90 day notice, should either decide to voluntarily terminate a clinical faculty appointment. This agreement may be terminated, with cause, at any time by NYITCOM.

Upon the completion of each individual training period, I will, if required, fully complete and return to NYITCOM, within 14 days, a performance evaluation for each of my students. Each student completing a rotation with me will complete a faculty evaluation form; such student evaluations of faculty are part of an ongoing process.

I hereby grant permission to the New York Institute of Technology to use my name in official university publications. Such official university publications may include printed materials, websites, videos, and advertisements.

With this application, I seek appointment as Clinical Faculty to provide clinical training for the NYITCOM medical students. I agree to follow the curriculum provided by the Office of Academic Affairs at NYITCOM and also agree to review, monitor, and provide feedback for the revision of the curriculum as needed and/or as requested by the Office of Academic Affairs. I understand and agree to keep student and other NYITCOM related information confidential and disclose such information only to authorized NYITCOM personnel.

With my signature, I attest the information provided in this application to be true.

Applicant's Signature:

Date:

My typed signature is my symbol of authentication where I willingly validate and endorse this document

Clinical Faculty Application Self-Identification Form

This University is an Equal Opportunity Employer and the information requested here is not included as part of the application process. Providing this information is voluntary and confidential. A decision not to provide this information will not result in any adverse treatment of your application. It is an unlawful employment practice for an employer to fail or refuse to hire, promote or discharge any individual, or otherwise to discriminate against an individual with respect to that individual's terms and conditions of employment, based on individual's race, sex, marital status, color, religion, national origin, sexual orientation, physical/mental disability or condition, or age (except for those less than 13) as defined by state and federal laws and regulation, except when bona fide occupational qualifications exist that restrict or exclude applicants based on that bona fide occupational qualification.

Race/Ethnicity: Please check one of the descriptions below corresponding to the ethnic group with which you most identify.

Hispanic or Latino: a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

White (Not Hispanic or Latino): a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Black or African American (Not Hispanic or Latino): a person having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino): a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Asian (Not Hispanic or Latino): a person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

American Indian or Alaska Native (Not Hispanic or Latino): a person having origins in any of the original peoples of North and South America (including Central America) who maintains tribal affiliation or community attachment.

Two or More Races (Not Hispanic or Latino): all persons who identify with more than one of the above five races.

I do not wish to complete this self-identification.

Teaching Role for NYITCOM Clinical Faculty Applications

Applicant Name:

Hospital Name:

The teaching role for the above doctor and hospital includes the following activities: (Check each item applicable)	
<input type="checkbox"/>	Presents lectures to residents and students
<input type="checkbox"/>	Clinical supervision in a private practice of residents and students
<input type="checkbox"/>	Clinical supervision in the hospital of residents and students
<input type="checkbox"/>	Rounding on hospital units with residents and students
<input type="checkbox"/>	Other (please indicate):

Hospital DME Signature:	Date:
DME Name (Typed):	