UNM Medical Group, Inc.

University of New Mexico Physicians

Second Year Advanced Education in General Dentistry (AEGD)
Resident Application
Postgraduate Year Two (PGY-2)

Send complete application to Berlin Rodriguez, 1801 Camino de Salud, Suite 1200 Albuquerque, NM 87131 or e-mail complete application to bprodriguez@salud.unm.edu

UNM Medical Group, Inc.
University of New Mexico Physicians

Attach Photo

APPLICATION FOR ADVANCED EDUCATION IN GENERAL DENTISTRY (AEGD)

POSTGRADUATE YEAR TWO (PGY-2) **Date of Application:** _____

Applicant Information

Gender: ☐ Female ☐ Male ☐ Transgender Social Security Number: _____

Full Name: _____
Last First M.I. Maiden or Other Names Used

Date of Birth:	**Current UNM Dental PYG-1(circle one): YES NO**
Place of Birth:	Federal Tax Identification Number: *(Indicate if PENDING)*
National Provider Identifier Number (NPI): *(Indicate if APPLIED)*	State Tax Identification Number: *(Indicate if PENDING)*
Medicaid Number: *(Indicate if PENDING)*	Medicare Number: *(Indicate if PENDING)*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Telephone Number: _____ Pager Number: _____

Cell Phone Number: E-mail:

Credentials Correspondence Address:

Department/ Name: _____

Address: _____
City *State* *ZIP Code*

Telephone Number: _____ Facsimile Number: _____

E-mail: _____

Military Service:

Branch: _____ Date of Service: _____

Rank: _____ Type of Discharge: _____

Citizenship/Immigration:

Status: _____ Immigration Certification Number: (if applicable): _____

Educational Commission for Foreign Medical Graduates Number (if applicable): _____ Date Issued: _____
(Please attach a copy of your ECFMG Certificate)

Languages:

Foreign Languages (spoken fluently by practitioner): _____

Certifications:

ACLS Certified: ☐ Yes ☐ No Expires: _____

ATLS Certified: ☐ Yes ☐ No Expires: _____

PALS Certified: ☐ Yes ☐ No Expires: _____

Hospital and Healthcare Affiliations

Please list all hospital staff membership and/or healthcare organization affiliations, and your status (active, courtesy, consulting, etc.). If an institution is no longer in existence, please provide an alternative source of verification. Use a separate paper, if necessary.

Current Primary Admitting Facility (Hospital Name): _____

Privileges Assigned: _____

Street Address:	Telephone Number:
City & Zip Code:	Facsimile Number:
Appointment Dates:	Type of Appointment:
Department Chair/Division Chief:	Telephone Number:
E-mail:	Cell Phone Number:

Facility Name: _____

Privileges Assigned: _____

Street Address:	Telephone Number:
City & Zip Code:	Facsimile Number:
Appointment Dates:	Type of Appointment:
Department Chair/Division Chief:	Telephone Number:
E-mail:	Cell Phone Number:

Facility Name: _____

Privileges Assigned: _____

Street Address:	Telephone Number:
City & Zip Code:	Facsimile Number:
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Facility Name: _____

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Street Address:	Telephone Number:
City & Zip Code:	Facsimile Number:
Appointment Dates:	Type of Appointment:
Department Chair/Division Chief:	Telephone Number:
E-mail:	Cell Phone Number:

Resident Locations

Please list all previous experience, including months and years, listing the most recent first. Attach a separate page if necessary.

Organization: ____________________

Type of Practice: ____________________

Street Address:	Telephone Number:
City & Zip Code:	Facsimile Number:
Begin Date (Month/Year):	End Date (Month/Year):
Department Chair/Division Chief:	Telephone Number:
E-mail:	Cell Phone Number:

Organization: ____________________

Type of Practice: ____________________

Street Address:	Telephone Number:
City & Zip Code:	Facsimile Number:
Begin Date (Month/Year):	End Date (Month/Year):
Department Chair/Division Chief:	Telephone Number:
E-mail:	Cell Phone Number:

Organization: ____________________

Type of Practice: ____________________

Street Address:	Telephone Number:
City & Zip Code:	Facsimile Number:
Begin Date (Month/Year):	End Date (Month/Year):
Department Chair/Division Chief:	Telephone Number:
E-mail:	Cell Phone Number:

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Organization: _____

Type of Practice: _____

Street Address:	Telephone Number:
City & Zip Code:	Facsimile Number:
Begin Date (Month/Year):	End Date (Month/Year):
Department Chair/Division Chief:	Telephone Number:
E-mail:	Cell Phone Number:

Please provide a written explanation for any gaps in work history of two (2) months or more.

Professional References

Please list three (3) professional peers with the same type of license, or a higher level of licensure, who are familiar with your professional performance in the past two (2) years. ***One of the references must be the Program Director of the General Practice Residency (GPR) or Advanced Education in General Dentistry (AEGD) where you completed your year one.***

Name & Title: _____ Specialty: _____

Company: _____ Telephone: _____

Address: _____

E-mail: _____

Name & Title: _____ Specialty: _____

Company: _____ Telephone: _____

Address: _____

E-mail: _____

Name & Title: _____ Specialty: _____

Company: _____ Telephone: _____

Address: _____

E-mail: _____

Licensure Registration Information

List all licenses held in all jurisdictions. Attach a separate page, if necessary.

State Professional License/Certification Number *(Indicate if Pending)*:	State:	Issue Date: Expiration Date:
State Professional License/Certification Number *(Indicate if Pending)*:	State:	Issue Date: Expiration Date:
State Professional License/Certification Number *(Indicate if Pending)*:	State:	Issue Date: Expiration Date:
State Professional License/Certification Number *(Indicate if Pending)*:	State:	Issue Date: Expiration Date:

Drug Certificate Information

Federal Drug Enforcement Administration (DEA) Registration: ☐ Not Applicable ☐ Pending State: _____

DEA Number _____ Expiration _____

State Controlled Substance Registration (CSR): ☐ Not Applicable ☐ Pending State: _____

DEA Number _____ Expiration _____

Educational Background

Did you complete the Advanced Dental Admission Test (ADAT)? ☐ Yes ☐ No If yes, please provide score: _____

Institution Name	Dates of Attendance	Degree(s) Earned

Professional Practice Questions

Please answer the following questions (circle yes or no). If you answer "YES" to any question, you must give details including name, address, and telephone number of significant parties on a separate sheet of paper. You must respond to each question.

1. Has your professional liability coverage been terminated by action of the insurance company (except as a result of the company ceasing to offer insurance coverage to physicians or other practitioners)?	Yes	No
2. Have you ever been denied professional liability insurance coverage?	Yes	No
3. Have your professional liability carrier ever excluded any specific procedures from your coverage?	Yes	No
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes	No
5. Have you ever ha any sanctions imposed by Medicare and/or Medicaid?	Yes	No
6. Have you ever been convicted of a misdemeanor or felony (excluding minor traffic violations) in the United States or any crime in another country?	Yes	No
7. Have you ever been arrested, indicted, charged, or been a defendant in a trial, regardless of the outcome, of any crime involving: intoxication, illegal use, possession or distribution of an illegal substance, trafficking of DEA Schedule II drugs, sexual offenses, domestic violence or harm to a minor?	Yes	No
8. Have you ever been subject to investigation by a government entity or licensing board that could have resulted, or did result, in licensure sanctions or other adverse actions, irrespective of the outcome?	Yes	No
9. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered, or denied?	Yes	No
10. Are any currently held licenses pending investigation or being challenged?	Yes	No
11. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes	No
12. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings)?	Yes	No
13. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked or not renewed, except for medical records delinquency?	Yes	No
14. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked or not renewed, except for medical records delinquency?	Yes	No
15. Have you ever resigned from a healthcare entity while under investigation for or to avoid modification, suspension, or termination of privileges?	Yes	No
16. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or surrendered, or is it currently being challenged?	Yes	No
17. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please list on a separate sheet of paper for each case (see page 10): • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery that led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit.	Yes	No

• Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney.		
18. Do you know of any reason why you cannot perform the essential duties of the clinical privileges/functions which you are requesting, with or without a reasonable accommodation according to acceptable standards of professional performance and without posing a direct threat to patients?	Yes	No
19. Do you use illegal drugs or have you illegally used drugs in the past five years?	Yes	No
20. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, prescription medication or alcohol?	Yes	No
21. Have you ever, for any reason resigned from or withdrawn from a medical or professional school or postgraduate training program?	Yes	No
22. Have you ever, for any reason been suspended, dismissed, or expelled from a medical or professional school or postgraduate training program?	Yes	No
23. Have you ever, for any reason been placed on probation or remediation, including academic probation or remediation, by a medical or professional school or postgraduate training program?	Yes	No
24. Have you ever, for any reason taken a leave of absence or break from, or had any interruptions or extensions in, a medical or professional school or postgraduate training program for any reason, personal or professional (including illness or disability, pregnancy or maternity, any academic issues, or other similar reasons)?	Yes	No

Disclaimer and Signature

I certify that my information are true and complete to the best of my knowledge. I agree to allow the UNM Medical Group, Inc. to contact my previous supervisor and references listed above.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____

Social Security Number: _____

Additional Information

Please attach the following information with your application. Failure to submit the information will result in an incomplete application.

- ☐ **A Current Resume**
- ☐ **Essay One: On a separate page of paper type your response to an account of a "helping incident" in which you were the person who provided the help. Include the nature and extend of the request, your assessment of the issue(s), problem(s), and situation(s). Describe how you came to be involved and what you did.**
- ☐ **Essay Two: On a separate page of paper type your response to a description of your PGY-1 experience.**
- ☐ **Essay Three: On a separate page of paper type your response to your impression of PGY-2 and your educational goals, including how this education will be used to meet your professional goals.**

Malpractice Claims History

(See page 8, question 17)

☐ Not Applicable

If applicable, please copy this form for each additional malpractice claim. Failure to complete this form in its entirety will result in a delay in processing of your application.

a. Name of Practitioner:
b. Name and Age of Claimant:
c. Date of Incident:
d. Location of Incident:
e. Date of Lawsuit Filed:
f. Name of Court:
g. Case Number:
h. Case History of Patient Care (Describe your involvement):
i. Alleged Malpractice:
j. Patient Outcome:
k. Status of the Case (with reference to you, specifically): ☐ Pending ☐ Dismissed Date: _____

☐ Denied	Date: _____
☐ Closed without payment	Date: _____
☐ Pre-trial settlement (amount: $_____)	Date: _____
☐ Settlement (amount: $_____)	Date: _____
☐ Verdict for Defendant (amount: $_____)	Date: _____
☐ Verdict for Plaintiff (amount: $_____)	Date: _____

l. Medical Legal Panel Decision: ☐ Votes in Favor ☐ Votes Against

m. Name, phone number, facsimile number & address of insurance carrier:

n. Name, phone number, facsimile number & address of defense attorney:

o. Provide any names and phone numbers of others who could provide additional information regarding this claim/suit: