

**APPLICATION FOR CLINICAL or ADJUNCT FACULTY APPOINTMENT**

MSU's Clinical/Adjunct faculty appointment system is used for those individuals whose primary responsibility and source of income is outside MSU, but who agree to provide educational services in support of MSU's mission. Those appointed in this system are also referred to as "prefix" faculty. Appointment length varies but is generally for three years and is renewable. Promotion is based on meeting established minimum criteria approved by the College of Human Medicine Advisory Council as well as specific department criteria.

**Please type or print all information. All fields are required. Incomplete applications or missing information may delay appointment.**

**COMMUNITY AFFILIATION:**

- Flint  Grand Rapids  Lansing  Midland  Traverse City  Upper Peninsula  Southeast Michigan

**DEPARTMENT:** I am requesting appointment in the department(s) of:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Emergency Medicine                            | <input type="checkbox"/> Pediatrics & Human Development | <input type="checkbox"/> Surgery                                    |
| <input type="checkbox"/> Family Medicine                               | <input type="checkbox"/> Psychiatry                     | <input type="checkbox"/> Translational Science & Molecular Medicine |
| <input type="checkbox"/> Medicine                                      | <input type="checkbox"/> Radiology                      | <input type="checkbox"/> Center for Ethics and Humanities           |
| <input type="checkbox"/> Obstetrics, Gynecology & Reproductive Biology |   | <input type="checkbox"/> <i>Uncertain – Please advise</i>           |

**DIVISION:**

- Division of Public Health

**NAME: FIRST** \_\_\_\_\_ **MIDDLE** \_\_\_\_\_ **LAST** \_\_\_\_\_

**SOCIAL SECURITY #:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_ **GENDER:**  Male  Female

**CITIZENSHIP:**  U.S. Citizen  Non Resident Alien  Non-Citizen Nat'l of U.S.  Permanent Resident

**TYPE OF VISA:** \_\_\_\_\_ **COUNTRY OF CITIZENSHIP:** \_\_\_\_\_

**ETHNICITY/RACE:**  Of Hispanic or Latino Origin  Not of Hispanic or Latino Origin

**Please check at least one status as well as all that apply:**  American Indian or Alaskan Native  Asian  
 Black or African American  Hawaiian/Pacific Islander  White

**PREFERRED MAILING ADDRESS:**  Home  Office  Other

(Street/City/State/Zip): \_\_\_\_\_

**SECONDARY MAILING ADDRESS:**  Home  Office  Other

(Street/City/State/Zip): \_\_\_\_\_

**HOME PHONE:** \_\_\_\_\_ **CELL PHONE:** \_\_\_\_\_ **BUSINESS PHONE:** \_\_\_\_\_

**E-MAIL:** \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

**NAME:** First \_\_\_\_\_ Last \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**MEDICAL PRACTICE NAME:** \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**GROUP AFFILIATION** (e.g., SHMG, Advantage Health): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**EDUCATION:**

**Degree 1:**

Most Relevant Highest Degree \_\_\_\_\_

Major Field of Study \_\_\_\_\_

School (Institution) \_\_\_\_\_

Date Degree Received \_\_\_\_\_

**Degree 2:**

Most Relevant Highest Degree \_\_\_\_\_

Major Field of Study \_\_\_\_\_

School (Institution) \_\_\_\_\_

Date Degree Received \_\_\_\_\_

**POSTGRADUATE TRAINING:**

**INTERNSHIP:** Institution \_\_\_\_\_ Dates \_\_\_\_\_

**RESIDENCY:** Specialty \_\_\_\_\_ Institution \_\_\_\_\_ Dates \_\_\_\_\_

Specialty \_\_\_\_\_ Institution \_\_\_\_\_ Dates \_\_\_\_\_

**FELLOWSHIP:** Specialty \_\_\_\_\_ Institution \_\_\_\_\_ Dates \_\_\_\_\_

**NATIONAL PROVIDER ID** \_\_\_\_\_

**MEDICAL LICENSE:**

License Number \_\_\_\_\_ State \_\_\_\_\_ Date Issued \_\_\_\_\_

License Pending? \_\_\_\_\_ (indicate reason, e.g., new resident or out-of-state)

**BOARD ELIGIBILITY/ CERTIFICATIONS:**

Certified?  Yes  No Certified Specialty \_\_\_\_\_ Date Issued \_\_\_\_\_

Other Specialty \_\_\_\_\_

If not board-certified, are you board-eligible?  Yes  No Eligible Specialty \_\_\_\_\_

**PRIVILEGES:**

Hospital \_\_\_\_\_ City/State \_\_\_\_\_

Hospital \_\_\_\_\_ City/State \_\_\_\_\_

**PREVIOUS ACADEMIC EXPERIENCE:**

Institution \_\_\_\_\_ Position \_\_\_\_\_ Years \_\_\_\_\_

Institution \_\_\_\_\_ Position \_\_\_\_\_ Years \_\_\_\_\_

**Please indicate the area(s) of academic service you are most interested in providing:**

- Teaching/precepting preclinical students (PBL, Clinical Skills, Ethics, guest lectures, etc.)
- Teaching/precepting clinical students in my office or the hospital
- Serving on a College of Human Medicine committee (Admissions, Curriculum Development, etc.)
- Acting as a formal mentor for students
- Teaching residents in a College of Human Medicine sponsored or affiliated residency program
- Engaging with students or residents on a research project
- Other \_\_\_\_\_

**ANY RELATIVE EMPLOYED BY MSU?**  Yes  No \*(If yes, name, relationship, title, department)

\_\_\_\_\_

**DISCLOSURE OF SIGNIFICANT FINANCIAL INTERESTS RELATED TO MSU**

Do you, your spouse, domestic partner, dependent children and/or other dependents residing with you have any financial interest related to your MSU responsibilities?  Yes  No  
If "Yes" please list the name of entities related to your MSU responsibilities in which you have a personal financial interest.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NOTE: You are not required to disclose travel that is reimbursed or sponsored by any of the following U.S. entities: government agencies; institutions of higher education; teaching hospitals or medical centers; or research institutes affiliated with a U.S. institution of higher education.

**PERSONAL CERTIFICATION:** I understand that it is my responsibility to send an updated [COI Disclosure Form](#) within thirty days of acquiring any new significant financial interest related to my responsibilities above or if the details/relationships with disclosed entities change.

**PLEASE INCLUDE A CURRENT CURRICULUM VITAE WITH THIS APPLICATION**

*To the best of my knowledge, I certify that all information provided in this application is correct.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_