

**APPLICATION FOR NON-PREFIX FACULTY APPOINTMENT**

Faculty who are granted an appointment in the Clinical/Adjunct appointment system with a “non-prefix” rank must be deeply involved in the college as evidenced by meeting at least one of the eligibility criteria listed below. Appointment length varies but is generally for three years and is renewable as long as the eligibility requirements continue to be met. Approval by the department chair and the dean’s office is required.

**ELIGIBILITY CRITERIA:**

**Indicate which of the following qualifies you for a non-prefix appointment:**

- I have an official administrative position in the college (e.g., Clerkship Director, Course Director, etc.) Official administrative positions in the college are designated as such by the dean’s office.

*My role:* \_\_\_\_\_

- I am paid by a College of Human Medicine-affiliated or College of Human Medicine-sponsored residency as core faculty or administrator (e.g., Residency Director). “Core faculty” means a significant amount of your effort is devoted to teaching/precepting, and you are paid by the residency program or clinical entity specifically for your teaching role.

*My role:* \_\_\_\_\_

- I am engaged in a meaningful, collaborative research relationship with the College of Human Medicine as adjudicated by the college Senior Associate Dean for Research.

*MSU department or faculty member I am working with:* \_\_\_\_\_

**COMMUNITY AFFILIATION:**

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

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

- Emergency Medicine  Pediatrics & Human Development  Surgery
- Family Medicine  Psychiatry  Translational Science & Molecular Medicine
- Medicine  Radiology  *Uncertain – Please advise*
- Obstetrics, Gynecology & Reproductive Biology

**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 \_\_\_\_\_

**EXPECTATIONS:**

***Please check all of the following, acknowledging your agreement with the expectations of this appointment:***

- I am able to demonstrate significant effort on MSU-related activities (generally considered to be at least 20%) across the three areas of teaching, scholarly productivity/research, and institutional service, as outlined in the CHM promotion criteria.
- I agree to make continuing meaningful contributions to the instructional mission of CHM.
- I have been made aware of the promotion criteria and the expectation that I will work toward academic promotion.

**ANY RELATIVE EMPLOYED BY MSU?**  No  Yes \*(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:** \_\_\_\_\_