



EM Fellowship Application, 2018-2019

Fellow Selection Criteria

- Completed, or in good standing and scheduled to complete by July 1, 2018, an AOA or ACGME-accredited residency in Family Medicine, Internal Medicine, Pediatric or Internal Medicine/Pediatrics. Other specialty training will be accepted on a case-by-case basis.
- Licensed to practice medicine in the state where training will occur before start of fellowship.
- ACLS and PALS certified.
- Able to obtain hospital credentials to practice at all training sites.
- Meet qualifications for Medicare, Medicaid, Blue Cross/Blue Shield of Alabama and other third-party payers.
- Eligible to work in the United States during the fellowship period.
- Provide a strong record of academic, clinical, and other personal achievements.
- Demonstrated commitment to clinical Emergency Medicine.

Materials needed for a complete application include:

1. Demographic and basic personal and educational information, authorization for background check, and a brief (less than 250 words) statement of knowledge of, interest in, and commitment to Emergency Medicine submitted on the application form and emailed to aheins@immh.com.
2. Current curriculum vitae, including all post-secondary education, certification, and licensing information, employment history including all supervisory or leadership positions and jobs that correspond to gaps in education history, and academic accomplishments including awards, presentations, and publications. Email to aheins@immh.com.
3. Official transcripts from medical school sent directly by mail or email to:

Alan Heins, MD, MPH, FACEP
EM Fellowship Director
1012 Brandywine Road
Tuscaloosa, AL 35406
aheins@immh.com
4. Two letters of recommendation, one from your residency director and the other from a physician who has knowledge of your character, medical knowledge and clinical skills. These should also be sent directly to Alan Heins, MD, MPH, FACEP, EM Fellowship Director, by mail at address above or may be scanned and emailed to aheins@immh.com. Physicians in practice for 5 or more years out of residency may substitute residency director letter with a letter from your current employer or practice associate.

APPLICATION

Applicant Information

Name	
Address	
Best Phone	
Best Email	

Applicant Statement

Insert a brief (less than 250 words) statement of knowledge of, interest in, and commitment to Emergency Medicine. You may paste from a word processing document, but some formatting may be lost. You may also send your statement as a separate sheet.

(Applicant statement here, or included as separate attachment)

This one application is sufficient to apply to any or all of our Emergency Medicine Fellowship Programs. Please select those programs below where you would like to be considered.

- Cullman Regional Medical Center** Located in Cullman, Alabama
CRMC is a 45,000 visit, moderate-acuity ED serving a diverse patient population.
Supplemental rotations occur at Highlands Medical Center (Scottsboro, AL) to provide additional small-town community hospital experiences. *5 fellows per year*

- Decatur Morgan Hospital – Decatur Campus** Located in Decatur, Alabama
Decatur is a 40,000 visit, moderate-acuity ED serving a diverse urban and rural patient population.
Supplemental rotations occur at Decatur Morgan Hospital—Parkway Campus (Decatur, AL) and Athens-Limestone Hospital (Athens, AL) to provide additional suburban community hospital experiences. *8 fellows per year*

- Princeton Baptist Medical Center** Located in Birmingham, Alabama
PBMC is a 45,000 visit, high-acuity urban ED serving a diverse patient population.
Supplemental rotations occur at Shelby Baptist Medical Center (Alabaster, AL) to provide additional community hospital experiences. *3 fellows per year*

- Shelby Baptist Medical Center** Located in Alabaster, Alabama
SBMC is a 45,000 visit, moderate-acuity ED serving a diverse suburban and rural patient population.
Supplemental rotations occur at Princeton Baptist Medical Center (Birmingham, AL) to provide additional urban hospital experiences. *3 fellows per year*

- St Francis Medical Center** Located in Monroe, Louisiana
SFMC is a 50,000 visit, moderate acuity urban ED serving a diverse patient population with a wide variety of emergency medical needs. *4 fellows per year*

Include with completed application and email to aheins@immh.com

- Curriculum Vitae
- Signed authorization for background check and signed disclosure for Fair Credit Reporting Act

Request

1. Official transcripts from your medical school to be sent directly by mail or email to:

Alan Heins, MD, MPH, FACEP
EM Fellowship Director
1012 Brandywine Road
Tuscaloosa, AL 35406
aheins@immh.com

2. Two letters of recommendation, one from your present residency director and the other from a physician who has knowledge of your character, medical knowledge and clinical skills. These should also be sent directly to Alan Heins, MD, MPH, FACEP, EM Fellowship Director, by mail at address above or by email to aheins@immh.com. Physicians in practice for 5 or more years out of residency may substitute residency director letter with a letter from your current employer or practice associate.

Key Dates

Application Period | August 1, 2017 – December 31, 2017

Early application is recommended since interview offers are made on a rolling basis. Applications outside of this period may be considered in special circumstances. Please email Dr. Heins to discuss at aheins@immh.com.

Interviews | September 15, 2017 – January 15, 2018

Prompt acceptance and scheduling of interviews is recommended since employment offers are made on a rolling basis.

Offers | Rolling

Offers to join the program will be made on a rolling basis after application review and interview until the classes at each fellowship site are full with a total of 15 fellows for the 2018-2019 academic year. Offers should be accepted or rejected within 10 days of receipt.

Program Starts | Monday, August 13, 2018

For additional information, please contact the EM Fellowship Director, Alan Heins MD, MPH, FACEP, at aheins@immh.com.



CONFIDENTIAL
Background Check Authorization

Print Name: _____
(First) (Middle) (Last)

Former Name(s) and Dates Used: _____

Current Address Since: _____
(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: _____
(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: _____
(Mo/Yr) (Street) (City) (Zip/State)

Social Security Number: _____ Date of Birth: _____

Telephone Number: _____ Cell Phone: _____

Driver's License Number/State:

In addition to the foregoing I hereby certify, under penalties of perjury, that I

HAVE HAVE NOT

- | | | |
|--------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | been convicted of a felony or misdemeanor other than a minor traffic violation; |
| <input type="checkbox"/> | <input type="checkbox"/> | had my professional license restricted or suspended in a State or a territory; |
| <input type="checkbox"/> | <input type="checkbox"/> | had my privileges refused or restricted by a Hospital; |
| <input type="checkbox"/> | <input type="checkbox"/> | filed for Bankruptcy; |
| <input type="checkbox"/> | <input type="checkbox"/> | been subject to a lien, either by the Internal Revenue Service, or a result of a judgment in a court of law; |
| <input type="checkbox"/> | <input type="checkbox"/> | been a Defendant in a medical malpractice case; |
| <input type="checkbox"/> | <input type="checkbox"/> | been the subject of an investigation by any State or Federal licensing agency or regulatory body; |
| <input type="checkbox"/> | <input type="checkbox"/> | been decertified by Center for Medicare/Medicaid Services ("CMS") |

If any of the above are checked "HAVE" please use the space below to explain the situation further. You may attach additional sheets if needed.

The information contained in this Authorization is correct to the best of my knowledge. I hereby authorize Island Medical Management Holdings, LLC (“IMMH”) and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report and/or a legal background check to be generated for the purposes of employment or provision of contractor services. I understand that the scope of the consumer report/investigative consumer and legal report may include, but is not limited to the following areas: verification of social security number; licensure; current and previous residences; employment history, education history, character references and employer references; drug testing results, civil and criminal case records from any or all federal, state, or county jurisdictions, driving records, birth records, marriage records and any other public records. I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration, CMS and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me, to IMMH or its authorized agents. I further authorize the complete release of any records or data pertaining to me which an individual, company, firm, corporation, or public agency may have, including information or data received from other sources.

I hereby release IMMH, its employees and agents and any individual, company, firm, corporation, or public agency including, but not limited to the Social Security Administration, law enforcement agencies, employers and their respective agents, officials, representatives, including officers, employees, or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may, at any time, result to me, my heirs, family, or associates because of good faith compliance with this Authorization.

Signature: _____ Date: _____

DISCLOSURE AND AUTHORIZATION FORM TO OBTAIN CONSUMER REPORTS FOR EMPLOYMENT PURPOSES

Please Read Carefully Before Signing the Authorization

DISCLOSURE

In considering you for employment and, if you are employed, in considering you for subsequent promotion, assignment, reassignment, retention, or discipline, Island Medical Management Holdings, LLC (“IMMH”) may request and rely upon one or more consumer reports or investigative consumer reports about you that we obtain from a consumer reporting agency, such as IntelliCorp Records, Inc.

IntelliCorp Records, Inc. can be contacted by mail at 3000 Auburn Dr, Suite 410; Beachwood, OH 44122; or phone: 1-888-946-8355; or website: www.intellicorp.net.

For explanation purposes:

- a “consumer report” is a written, oral or other communication of any information by a consumer reporting agency bearing on your credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in making an employment-related decision about you. Such information may include, for example, credit information, criminal history reports, or driving records; and
- an “investigative consumer report” is a consumer report in which information on your character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with your prior employers, neighbors, friends, or associates, or with others who may have knowledge concerning any such items of information. In the event an investigative consumer report is requested about you, you are entitled to additional disclosures regarding the nature and scope of the investigation requested, as well as a written summary of your rights under the Fair Credit Reporting Act (“FCRA”).

Under the FCRA, before the Company can obtain a consumer report or investigative consumer report about you for employment purposes, we must have your written authorization. Before we take adverse action on the basis, in whole or in part, of information in that report, you will be provided a copy of that report, the name, address, and telephone number of the consumer reporting agency, and a summary of your rights under the FCRA.

AUTHORIZATION

I have read and understand the foregoing Disclosure, and authorize to obtain and rely upon consumer reports or investigative consumer reports in considering me for employment and, if I am employed, in considering me for subsequent promotion, assignment, reassignment, retention, or

discipline. By my signature below, I authorize IMMh to obtain any such reports and to share the information received with any person involved in the employment decision about me.

I also agree that this Disclosure and Authorization in original, faxed, photocopied, or electronic (including electronically signed) form will be valid for any consumer reports or investigative consumer reports that may be requested about me by or on behalf of the Company.

Printed Name

Applicant Signature

Date