THE EMORY PHYSICIAN ASSISTANT SURGICAL RESIDENCY PROGRAM

APPLICATION FOR ADMISSIONS

Instructions:

1. Complete application in its entirety, save, and submit electronically as an attachment to: marjorie.mckellar@emoryhealthcare.org.
   If necessary to submit as regular mail, send to this address:
   Emory Surgical PA Program
   Winship Cancer Institute
   1365 Clifton Road, NE, Suite C-2052
   Atlanta, GA 30322

2. Include a 1-page typed personal statement describing yourself, your background, and why you desire a career in surgery. Include as an email attachment to this application.

3. Include a Passport sized photo and a copy of current CV as email attachments to this application.

4. Submit hard or scanned copies of ACLS & BLS cards.

5. Submit transcripts from your PA program to the Program Director in a sealed envelope with the author's signature across the seal of the envelope.

6. Submit three letters of professional recommendation on behalf of your application; one must be from your program director. May be sent via email directly from the reference to Margi McKellar at marjorie.mckellar@emoryhealthcare.org.

7. Program Calendar:

Event	February Start
Application Deadline	September 15
Interview Notification	Rolling
Interview Dates	First week of October
Selection Notification	Second week of October
Commitment to Program	October 31
Start Date	February 1

Emory PA Surgical Residency Program Application

APPLICANT INFORMATION

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Date Available: _____ Social Security No.: _____

Are you a citizen of the United States? YES ☐ NO ☐ If no, are you authorized to work in the U.S.? YES ☐ NO ☐

Have you ever worked for this company? YES ☐ NO ☐ If yes, when? _____

Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, explain: _____

EDUCATION

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Diploma: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Other: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

REFERENCES

List three professional references. Each should submit letter of support for application ***(one letter must be from your Program Director)***

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

PREVIOUS EMPLOYMENT AND/OR MEDICAL EXPERIENCE: Include all adult employment experiences, accounting for any all gaps in employment

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

MILITARY SERVICES

Branch: _____ From: _____ To: _____

Rank at Discharge: _____ Type of Discharge: _____

If other than honorable, explain: _____

DISCLAIMER AND SIGNATURE

I hereby authorize Emory Healthcare and The Emory Clinic, Inc., the medical staff(s) at Emory Healthcare and The Emory Clinic, Inc., facilities, and their representatives to consult with administrators and members of the medical staff of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my clinical competence, character and ethical qualifications. I also consent to the inspection by Emory Healthcare and The Emory Clinic, Inc., the medical staff(s) at Emory Healthcare and The Emory Clinic, Inc., facilities and its representatives of records and documents that may be material to an evaluation of my qualifications for staff membership. I hereby release from liability any and all individuals and organizations who provide, in good faith, information to Emory Healthcare and The Emory Clinic, Inc., or medical staff(s) at Emory Healthcare and The Emory Clinic, Inc., and I hereby consent to their release of such information to all personnel involved in the credentialing process at any other facility to which the applicant has applied and which is a part of the Emory Healthcare and The Emory Clinic, Inc.

I understand that additional information concerning my health may be required for the consideration of this application, and that my health as it relates to my ability to perform my medical staff duties appropriately will be an ongoing consideration.

I agree that my activities as a member of the medical staff will be bound by the provisions of the Institutional Bylaws, Rules and Regulations, and Code of Conduct. I understand that any significant misstatement in or omission from this application will constitute cause for immediate denial of appointment or summary dismissal from this Program.

I consent to the release of information provided in this application to any insurance plan in which Emory Healthcare and The Emory Clinic, Inc., or a component Emory Healthcare and The Emory Clinic, Inc., is a participating entity, subject to Emory Healthcare and The Emory Clinic, Inc., receiving from the plan an authorization for the release of such information, which I have executed.

I hereby declare that the statements in this application and all attachments hereto are complete and accurate.

Signature: _____ Date: _____