SRI DEVARAJ URS ACADEMY OF HIGHER EDUCATION & RESEARCH

A DEEMED TO BE UNIVERSITY (Declared under section 3 of UGC Act 1956) TAMAKA, KOLAR, Karnataka, India, Phone : 08152-243003/243004/243009, e-mail:registrar@sduu.ac.in,

FACULTY RECRUITMENT

Applications are invited from eligible candidates as per M.C.I norms in the prescribed format (available at **www.sduu.ac.in**) for the following positions: **Professor:** TB & CD, Dermatology and Emergency Medicine; **Associate Professor:** Psychiatry, TB & CD, Dermatology, Paediatrics, Orthopaedics, ENT, OBG, Radio-Diagnosis & Emergency Medicine; **Asst. Professor:** General Medicine, Paediatrics, Surgery, Orthopaedics & OBG; **Sr. Resident:** TB & CD and Anaesthesiology; **Jr. Resident:** Psychiatry, TB & CD and Emergency Medicine; **Speech-Language Pathologist and Audiologist**: Speech Language Pathology & Audiology. Duly filled applications are required to reach the Office of The Registrar, Sri Devaraj Urs Academy of Higher Education and Research, Tamaka, Kolar-563 103, Karnataka by 15th June 2019 by post or by e-mail (**registrar@sduu.ac.in**). Shortlisted candidates would be intimated about the date of interview.

No. SDUAHER/KLR/ADMN/ 463 /2019-20, Date 16-05-2019 **Sd/-Registrar**

"APPLICATION FOR APPOINTMENT TO MEDICAL STAFF"

LAST NAME	**FIRST NAME**	**MIDDLE NAME**	**Degree**

Other Name Used/Maiden Name _____
Specialty:

DEGREE CERTIFICATION			
List the certifying Degree and Medical council, the specialty, the date of certification/recertification & expiration.			
Name of University **1.** **2.** **3.**	Specialty	Certification/Recertification Date(s)	Expiration Date
Name of Medical Council 1.	Specialty	Certification/Recertification Date(s)	Expiration Date

☐ University/Council certification in process. Specialty_____ ☐ Date scheduled or taken ___/___/___

GENERAL INFORMATION			
Citizenship (If foreign national Status)	Aadhar Number	Date of birth	Employee No
PRIMARY OFFICE ADDRESS:	Approximate distance from hospital:		
Street and house/flat Number	City	State	PIN
Telephone Number FAX Exchange Number	Name of HOD		
SECONDARY OFFICE ADDRESS:	Approximate distance from hospital:		
Street and Suite Number	City	State	PIN
Telephone Number ( ) FAX ( )			
HOME ADDRESS:	Approximate distance from hospital:		
Street Address	City	State	**PIN**
Home Phone	Mobile Number ( )		

LICENSES AND REGISTRATION			
State	License Number	Date Granted	Expiration Date
State	License Number	Date Granted	Expiration Date
State	License Number	Date Granted	Expiration Date

EDUCATION/TRAINING	
Medical School	Name
	Address, City, State, PIN
	Dates of Attendance Degree Granted/Date From: To:
	If Foreign Medical Graduate: Date Issued:
RESIDENCY #1	Name
	Address, City, State, PIN
	Dates of Attendance Specialty From: To:
	Name of Program Director
RESIDENCY #2	Name
	Dates of Attendance Specialty From: To:
	Name of Program Director

FELLOWSHIP	Name
	Address, City, State, PIN
	Dates of attendance Specialty From: To:
	Name of Program Director

WORK HISTORY/HOSPITAL AFFILIATIONS, PAST AND PRESENT	
List work history, starting with the present. Include office practice, teaching appointments, employers, current and past hospital affiliations. If additional space is needed, provide details on separate sheet and attach.	
Name of Organization, Hospital, or Office Practice	Address, City, State, PIN
From: To:	Position
Name of Organization, Hospital, or Office Practice	Address, City, State, PIN
From: To:	Position
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From: To:	Position
Name of Organization, Hospital, or Office Practice	Address, City, State, PIN
From: To:	Position
Name of Organization, Hospital, or Office Practice	Address, City, State, PIN
From: To:	Position

PERSONAL REFERENCES	
List three peer references - *NOT RELATED TO YOU OR A PROSPECTIVE PARTNER* - who have personal knowledge of your current clinical ability, ethical character, and ability to work cooperatively with others. These references should have acquired their knowledge through recent observation of your professional performance and, ***at least one must have had organizational responsibility for supervision of your performance. (e.g. department chair, service chief, training program director).***	
Name	Address
Relationship	City, State, PIN
Name	Address
Relationship	City, State, PIN

PROFESSIONAL LIABILITY INSURANCE INFORMATION	
NAME OF CURRENT CARRIER:	ADDRESS:
POLICY LIMITS	POLICY NUMBER
DATE UNDERWRITTEN:	DATE OF EXPIRATION:
NAME(s), ADDRESS(s), AND POLICY NUMBERS FOR ADDITIONAL PROFESSIONAL LIABILITY INSURANCE CARRIERS YOU HAVE HAD OVER THE PAST FIVE YEARS:	

PROFESSIONAL BACKGROUND

Please answer the following questions regarding your professional background. If the answer to any question is "yes", please provide the nature and specific details on a separate sheet and attach.

	YES	NO
1. Have you ever voluntarily or involuntarily surrendered, or had any pending or Completed action involving the denial, revocation, suspension, reduction, Limitation, probation, reprimand, or non-renewal of,		
a) A license or certificate to practice medicine or any profession in any state Or country	☐	☐
b) Drug Enforcement Agency or other controlled substance license or registration	☐	☐
c) Membership or fellowship in any local, state, or national professional Organization	☐	☐
d) Specialty or subspecialty board certification or eligibility	☐	☐
e) Faculty membership at any medical or other professional school	☐	☐
f) Staff membership or clinical privileges at any hospital, clinic, or Healthcare institution	☐	☐
2. Has any hospital, health plan, or government sponsored program ever restricted, Suspended, invoked probation, or rejected or terminated your contract?	☐	☐
3. Have you ever been named as a defendant in a case alleging medical negligence, Or has a suit for any alleged malpractice ever been brought Against you?	☐	☐
4. Do you have any physical or mental health condition, treated or untreated, Which in any way impairs your ability in terms of skill, attitude, or judgment To practice to the fullest extent of your license and qualifications or in any way Poses a risk of harm to your patients?	☐	☐
5. Have you ever been convicted of a felony, or currently have felony charges Pending?	☐	☐

APPLICANT'S CONSENT AND RELEASE

I hereby apply for appointment to the Medical Staff of RLJHRC. In making application for appointment to the Medical Staff of RLJHRC, I certify that I have received, read, and agree to be bound by the Medical Staff Bylaws, Rules and Regulations and related manuals, and the current hospital policies that apply to my activities as a Medical Staff appointee and that are consistent with the Medical Staff Bylaws, Rules and Regulations and related Manuals. Moreover, I specifically pledge that I will maintain an ethical practice, provide for continuous care of all my Patients, refrain from fee-splitting or other inducements relating to patient referral, and refrain from providing "ghost" Surgical or medical services.

I certify that there has not been any unsuccessful or currently pending challenges to licensure or registration, no loss of medical or dental organization membership, nor loss of medical staff membership or privileges at another hospital, except as noted herein. I understand that my competence and general functioning and performance with regard to my Patients and my duties and obligations as a Medical Staff appointee of State Hospital, will be reviewed from time to Time by my peers working within the structure of the Medical Staff in accordance with the Bylaws thereof. I hereby give my permission for, and in fact request, such review pursuant to my appointment and reappointment to the Medical Staff of State Hospital, that I will not bring legal action to prevent such review or to recover damages from those participating in such review.

By applying for Medical Staff appointment, I accept the following conditions below during the processing and Consideration of my application and for the duration of my medical staff appointment regardless of whether or not I Am granted Medical Staff appointment and clinical privileges:

a) I extend absolute immunity to and release from any and all liability, RLJHRC, its authorized representatives, and any third parties, as defined in subsection (c) below, for any acts, communications, reports, statements, documents, recommendations or disclosures involving me, performed, made, requested or received by any third party, including otherwise privileged or confidential information. The foregoing shall be privileged to the fullest extent permitted by law; such privilege shall extend to the hospital and its authorized representatives, and to any third parties.

b) I specifically authorize the hospital and its authorized representatives to consult with any third party who may have information, including otherwise privileged information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on my satisfaction of the criteria for Medical Staff appointment as well as to inspect any and all communications, reports, statements, documents, recommendations, or disclosures of said third parties relating to such questions. I also specifically authorize said third parties to release such information, including any and all peer review material from any and all hospitals wherein I have held appointments, to the hospital and its authorized representatives upon request.

c) The term "hospital and its authorized representatives" means RLJHRC and any of the following individuals who have any responsibility for acting upon my application for Medical Staff appointment: the members of the hospital's Board and their appointed representatives, the Medical Superintendent or his designees, other hospital employees, consultants to the hospital, the hospital's attorney(s) and his/her partners, associates or designees, and all appointees to the Medical Staff. The term "third parties" means all individuals, including appointees to the medical staffs of other hospitals or physicians or health practitioners, nurses or other government agencies, organizations, associations, insurance companies, managed care organizations, credentials verification

organizations, partnerships and corporations, whether hospitals, health care facilities or not, from whom information has been requested by the hospital or its authorized representatives or who have requested such information from the hospital and its authorized representatives.

I also agree to provide any additional information as may be requested by the hospital or its authorized representatives. Failure to produce this information will prevent my application from being evaluated and acted upon. A copy of this consent and release is a binding as the original. In submitting this application for the purpose of securing appointment to the Medical Staff of RLJHRC, I hereby voluntarily state that all of the information above is complete and truthful. I also voluntarily state that I have made no effort to evade telling the complete truth regarding my professional career. I understand that any incomplete or false statement will lead to automatic withdrawal of this application for appointment. Should I be appointed to the Medical Staff of RLJHRC and it is subsequently found that any statement above is false I understand that my Medical Staff appointment and privileges will be automatically terminated.

SIGNATURE_____ DATE_____

PRINTED OR TYPED NAME._____