

**The Johns Hopkins Hospital
 Department of Anesthesiology/Critical Care Medicine
 Postgraduate Physician Assistant Critical Care Residency Program**

PERSONAL INFORMATION

Last Name	First Name	Middle name	Date of Birth
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Present Address (Street)	City and State	Zip Code	Telephone/e-mail
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Home Address (Street)	City and State	Zip Code	Telephone/e-mail
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U. S Citizen Yes No	Social Security Number
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EDUCATION AND TRAINING (Refer to on-line directions for submission of transcripts)

College(s)	Year Graduated and Degree
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P.A. School	Month and Year Graduated
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NCCPA Certification	Eligible Yes No	Date Certified	Certificate Number
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Other Certifications

REFERENCES (Refer to on-line directions for submission of recommendation letters)

Name	Telephone/e-mail
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Address (Street)	City and State	Zip Code
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Name	Telephone/e-mail
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Address (Street)	City and State	Zip Code
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Name	Telephone/e-mail
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Address (Street)	City and State	Zip Code
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Important: A completed application includes this form, completed online JHH application, official transcripts from colleges and the PA school, copies of BLS and ACLS certification cards, a one page typewritten narrative stating why you are interested in postgraduate surgical training, three applicant evaluation forms (including one from your PA Program), official NCCPA Exam scores (if certified), a signed copy of the Authorization Agreement, a current resume, and a check in the amount of \$45, payable to "Johns Hopkins", to cover the application fee. Program admission is contingent upon the satisfactory completion of Employee Health Screening and the Johns Hopkins Hospital Credentialing Process. **All application materials must be received by July 1 to be considered.**

Please mail all application materials in one envelope to:

Sarah Sloane, BA, Project Coordinator
 The JHH Post-Graduate Physician Assistant Critical Care Residency
 600 North Wolfe St.
 Halsted 600
 Baltimore, MD 21287

AUTHORIZATION AGREEMENT

I hereby authorize The Johns Hopkins Hospital (JHH), the medical staff(s) at JHH-operated 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 Johns Hopkins Hospital, the medical staff(s) at JHH-operated 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 Johns Hopkins Hospital or the medical staff(s) at JHH-operated facilities, 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 Johns Hopkins Hospital.

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 & 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 JHH, or a component of JHH, is a participating entity, subject to JHH 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 of Applicant

Date

Johns Hopkins Hospital

Postgraduate Physician Assistant Critical Care Residency

Applicant: Please fill in your name, social security number and mailing address, and sign waiver. Provide a standard business size envelope to evaluator.

APPLICANT'S WAIVER OF RIGHT OF ACCESS TO CONFIDENTIAL STATEMENT: I hereby freely and voluntarily waive my right of access to any information contained on this the recommendation form and agree that the statement shall remain confidential.

Evaluator: Because of federal legislation giving students access to educational records, the PA Surgical Residency Program cannot guarantee the confidentiality of your statement unless the applicant has signed the Waiver printed at right.

(signature)

(date)

Applicant's Name: _____
Last First Middle Social Security Number

Applicant's Mailing Address: _____
Street City State Zip

To the person recommending the applicant: The Johns Hopkins Hospital Postgraduate PA Critical Care Residency Program greatly appreciates your completion of this form. Please return this form directly to the applicant. Seal your evaluation in the envelope provided by the applicant, and write your name across the back seal.

For how long, and in what relationship, have you known the applicant? _____

Please comment on the strength and weaknesses of the candidate according to your knowledge of him/her, in the following areas:

Intellectual Ability: _____

Motivation/Perseverance: _____

Ability To Work With Others: _____

Maturity/Emotional Stability: _____

Personal Integrity: _____

Professionalism: _____

Flexibility/Ability to Adapt: _____

Have you observed the applicant's interactions with patients? Yes No

If yes, please comment on the applicant's interaction style: _____

Additional comments: _____

May we contact you by telephone for additional information? _____

Recommendation concerning admission (check one):

- The applicant has my highest recommendation.
- I recommend the applicant with confidence.
- I recommend the applicant with some reservations.
- I do not recommend the applicant.

Signature _____ Date _____

Name Printed or Typed _____ Title/Dept. _____

Institution _____

Address _____

Telephone No _ (____) _____ E-Mail _____

Upon completion, please seal this form in the envelope provided by the applicant and place your signature across the back seal. Return the sealed envelope directly to the applicant. The applicant submits all application materials in one envelope. All application materials must be received by JULY 1 to be considered.