

(This form may be used for all Colleges if so desired - but must be used for College of Medicine)

1. Please print or type
2. Return completed application to chairman of department as soon as possible. No appointment in the College of Medicine can be processed without the attached information.
3. Use additional sheets for information if needed.
4. Please enclose Loyalty Oath, Affirmation of Signature, Completed W-4 form if applicable, Completed Hospital application (if applicable).
5. The following are definitions of terms used on Application Form No. 2.

MAJOR AREAS OF RESPONSIBILITY

Should indicate major functional emphasis of activity in any combination of teaching (T), research (®), service (S), administration (A), or other (O). Check all that apply. If a primary responsibility exists, enter the letter "P" in appropriate column.

NATURE OF EMPLOYMENT

If no pay - (V) volunteer. If paid - (PTS) part-time salaried, (SFTA) strict full time in affiliated teaching hospital, (SFT) strict full time in medical college, (GFT) geographic full time in college of medicine, (GFTA) geographic full time in affiliated teaching hospital. Consult departmental secretary or academic personnel office for additional assistance.

TYPE OF EMPLOYMENT (Past Professional Employment History)

| | | |
|--|------------------------------------|--------------------------------|
| Academic (Enter name of school; clearly indicate if medical school, rather than parent institution). | | |
| Private practice of medicine | Training only | U.S. hospitals (non-federal) |
| Government-PHS (including hospitals) | Foundation (or research institute) | U.S. State or Local Government |
| Government-Military (including hospitals) | Industry or Business | Foreign - non-academic |
| Government-Veterans Affairs (including hospitals) | Other (specify) | |

TERMS USED ON APPLICATION PORTION MARKED "WITH REMUNERATION"

Questions pertaining to Predoctoral and Postdoctoral support

Discipline: Should indicate in broad terms the field of study for specialty, if relevant, in which training was taken.

| | | | | |
|----------|-------------------------------|---------------|-----------------------|----------------------------------|
| Purpose: | Complete Degree | Training only | Training and research | Training, teaching, and research |
| | Complete additional doctorate | Teaching only | Teaching and research | |
| | Specialty training | Research only | Training and teaching | |

Source of Award: May also be used for AGENCY

Abbreviations

| | | | | | |
|------------|--|-----------|----------------------------------|------|----------------------|
| NIH | National Institute of Health | NSF | National Science Foundation | ACAD | Academic |
| PHS | Other Public Health Service | VA | Veterans Administration | RMP | Regional Medical |
| CPEHS | Consumer Protection & Environment | FED-Other | Federal-Other | DOD | Dept. Of Defense |
| HSMHA | Health Services & Mental Health Administration | ACAD-F | Academic Foreign | AEC | Atomic Energy |
| SRS | Social Rehabilitation Services | FOR | Foreign | NASA | National Aeronautics |
| SSA | Social Security Administration | FDN | Foundation, society, association | OEO | Economic Opportun. |
| OE | Office of Education | IND | Industry, business | FED | Federal other, |
| DHEW-other | All other HEW | | All other, please specify | | Please specify |

COMPLETE BOTH PAGES OF THIS FORM

NAME: (Last) _____ (First) _____ (Middle) _____ Social Security Number _____ Date of Birth _____

Place of Birth: (City) _____ (State) _____ (Country) _____ Sex M _____ F _____ Race Wh _____ BI _____ Hi _____ A/PI _____ AI/AN _____

Home Address: (Street) _____ (City) _____ (State) _____ (ZIP Code) _____ Home Phone _____

Office Address: (Street) _____ (City) _____ (State) _____ (ZIP Code) _____ Business Phone _____

Marital Status: Single _____ Married _____ Divorced _____ Separated _____ Spouse's Name (if applicable): _____

Citizenship: (Country) _____ Former Citizenship (if naturalized): _____ Date of Naturalization: _____

Visa Status: Temporary _____ Permanent _____ Visa Symbol _____ Length of Stay: _____

Have you held a previous appointment at this Health Sciences Center: Yes _____ No _____ If yes, with remuneration _____ without remuneration _____

If with remuneration: Title _____ Department: _____

Are you presently employed at this Health Sciences Center: Yes _____ No _____ If yes, present title and department: _____

| Memberships in Associations or Societies (Major) | Hospital Staff Memberships (Major) | Research Projects (Major) |
|--|------------------------------------|---------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please use additional sheets of paper to complete above questions if necessary

Major Publications: _____

Please use additional sheets of paper to complete above question if necessary

EARNED DEGREES (List all degrees) If no earned degrees, please check _____

| | Specific Degree | Field of Study | Institution Conferring Degree | Name State of Foreign | Year Started | Year Completed |
|--------------------------|-----------------|----------------|-------------------------------|--------------------------|--------------|----------------|
| M.D. or equivalent | _____ | _____ | _____ | _____ | _____ | _____ |
| Ph.D. or equivalent | _____ | _____ | _____ | _____ | _____ | _____ |
| Other Health Prof. Doct. | _____ | _____ | _____ | _____ | _____ | _____ |
| Masters | _____ | _____ | _____ | _____ | _____ | _____ |
| Bachelors | _____ | _____ | _____ | _____ | _____ | _____ |
| Additional Degree(s) | _____ | _____ | _____ | _____ | _____ | _____ |

| INTERNSHIPS Please check if none _____ | U.S. Hospital | City | State | From | Years Completed |
|--|---------------|-------|-------|-------|-----------------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

| RESIDENCIES Please check if none _____ | U.S. Hospital | City | State | Service | From | Years Completed |
|--|---------------|-------|-------|---------|-------|-----------------|
| _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ |

U.S. Board Certification Please check if none _____

First Certification: _____ Year: _____ Second Certification: _____ Year: _____

Non-certified Specialization Please check if none _____ Specialty _____

Foreign Specialty Certification Please check if none _____ Specialty _____ Year _____

PAST PROFESSIONAL EMPLOYMENT HISTORY: (Limit to last 10 years, beginning with most recent) Year of First Medical School Faculty Appointment _____

COMPLETE COLUMNS BELOW FOR MEDICAL COLLEGE EMPLOYMENT ONLY

| Years From | To | Type of Employment (If academic, enter school name) | Major Areas of Responsibility | | | | | Department | Nature of Employment | Academic Rank | Administrative Title |
|---------------|-------|--|-------------------------------|---|---|---|---|------------|----------------------|---------------|----------------------|
| | | | T | R | S | A | O | | | | |
| _____ | _____ | _____ | | | | | | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | | | | | | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | | | | | | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | | | | | | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | | | | | | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | | | | | | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | | | | | | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | | | | | | _____ | _____ | _____ | _____ |

Basic Specialty(s) Please check if none _____ (a) _____ (b) _____ (c) _____

Have you ever served as a volunteer non-salaried faculty member at a medical school? Yes _____ No _____ If yes, latest year _____

Check source from which you originally entered med school employment: Training program _____ Private Practice _____ Federal government _____ Educational institution other than medical school _____ Residency _____ State or local government _____ Other (specify) _____

COMPLETE FOLLOWING QUESTIONS ONLY IF APPOINTMENT IS WITH REMUNERATION

Predocctoral Support in the USA Please check if none _____

| Institution | Discipline | Purpose | Source of Award | From | Years To |
|-------------|------------|---------|-----------------|-------|----------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Postdoctoral Support in the USA Please check if none _____

| Institution | Discipline | Purpose | Source of Award | From | Years To |
|-------------|------------|---------|-----------------|-------|----------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Signature _____

REMARKS