Winthrop University Hospital

Physician Assistant Surgical Critical Care Residency Program

Admission Requirements and Application Instructions:

Notify the residency program of your intention to apply by sending an email to:
frizzuto@winthrop.org

Submit the following requirements in ONE envelope:

- Completed application form
- Personal statement
- Curriculum vitae
- 3 Applicant Evaluation Forms
  - (You must use Evaluation Form template available via this website. One Letter MUST be from the Director of your PA Program. Each letter must be returned to you, the applicant, in a sealed envelope with the author's signature across the seal.)
- PA Program Transcripts
- Passport photo
- Application fee (Non-refundable check $25.00 made out to Winthrop University Hospital)

Please mail all application materials, in one envelope, to:

Physician Assistant Surgical Residency Program
Winthrop University Hospital
Attention: Frank Rizzuto RPA-C, Program Director
Department of Cardiovascular Surgery- 4 Main
259 First Street
Mineola, New York 11501

When your application is received you will be sent a letter of acknowledgement.

APPLICATION DEADLINE August 1, 2013

Program start date October 2013

Winthrop University Hospital

Physician Assistant Surgical Critical Care Residency Program

Application Form

Personal

Last Name | First Name | Middle Name | Date of Birth

Current Address (Street) | City and State | Zip Code | Telephone

Home Address (Street) | City and State | Zip Code | E-mail

U.S. Citizen ___ Yes ___ No | Social Security Number

Education and Training (use space below for additional information as necessary)

College | Year Graduated | Degree Obtained

College | Year Graduated | Degree Obtained

P.A. School | Month and Year Graduated

NCCPA Certification # | Date Certified | Eligible yes/no

Other Certifications

Do you currently hold a PA license in any state? ___Yes ___No License number _____

Have you ever been convicted of a felony in any state, or had a professional license revoked? __Yes __No

Have you ever been subject to a professional disciplinary action/suspension/probation? __Yes __No

Letters of Recommendation (please send them the template available via this link)

Please provide the names of three people who will be sending recommendation letters on your behalf.

Name | Title/Position | Daytime Phone Number

Name | Title/Position | Daytime Phone Number

Name | Title/Position | Daytime Phone Number

Personal Statement

Please submit a one page essay describing your career goals and source of interest in surgical critical care.

Additional Relevant Information

Attestation

I certify that the information in this application is complete and correct to the best of my knowledge and belief.

Signature of Applicant | Date

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Winthrop University Hospital

Physician Assistant Surgical Critical Care Residency Program

Department of Thoracic and Cardiovascular Surgery - 4 Main

Mineola, New York, 11501

Authorization Agreement

I hereby authorize Winthrop University Hospital, the medical staff(s) at Winthrop University Hospital 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 Winthrop University Hospital, the medical staff(s) at Winthrop University Hospital 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 Winthrop University Hospital or medical staff(s) at Winthrop University Hospital 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 Winthrop University Hospital Health Care System.

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 Winthrop University Hospital, or a component of Winthrop University Hospital, is a participating entity, subject to Winthrop University Hospital 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
