



Carolinus Rehabilitation

*Uncompromising Excellence. Commitment to Care.*

# ORTHOPAEDIC PHYSICAL THERAPY CLINICAL RESIDENCY PROGRAM APPLICATION

*(Please print legibly)*

## Resident Applicant Profile

Name \_\_\_\_\_ Date \_\_\_\_\_

**Home** Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

Home email address \_\_\_\_\_

**Work** Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

Work email address \_\_\_\_\_

APTA membership number \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Phone No. \_\_\_\_\_

## Professional License Detail

State:	License Type:	License No.:	Issue Date:	Expiration Date:
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## Board Certification Detail

Issuing Board	Certification Credential	Certificate No.	Issue Date	Expiration Date

Please list the issuing organization and expiration date of your current CPR certification \_\_\_\_\_

## Employment Status

Date of Hire \_\_\_\_\_ Employment Description:  Full Time  Part Time  Pool or PRN

Current Job Title \_\_\_\_\_

Do you require any special accommodations to ensure a satisfactory learning experience?  yes  no If yes, please detail:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





**Checklist:** Please ensure that each of the following items accompanies your application. The application will not be processed until all of these documents are submitted.

- ✓ Copy of professional practice license(s) with expiration date.
- ✓ Three letters of endorsement (these letters should be from licensed health care providers with at least one from a person who was your supervisor or clinical instructor). Recommendations from physical therapists will be most strongly considered. These letters of endorsement may be submitted separate for this application but sent to the same address as below.
- ✓ Current curriculum vitae or professional resume.
- ✓ CPR certification card with expiration date.

**It is the applicant's responsibility to submit three complete copies of the entire application and its surrounding documentation.**

Upon completion, this application should be sent to David Aiken at Carolinas Rehabilitation - Monroe; 1106 Reynolds St. Ste 200, Monroe, NC 28112

Signature: \_\_\_\_\_

Applicant \_\_\_\_\_

Date \_\_\_\_\_

**ATTESTATION QUESTIONS**

Please answer the following questions "Yes" or "No". **If you answer to any of the questions is "Yes", please provide complete details on a separate sheet.**

QUESTION	QUESTION	YES	NO
1.	Has your license to practice medicine in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, or subject to probationary conditions, or have you been fined or received a letter of reprimand – or is such action pending?		
2.	Has your Drug Enforcement Administration (DEA) certification or an applicable narcotic certification ever been restricted, limited, suspended, revoked, not renewed, or subject to probationary conditions, or have you been fined or received a letter of reprimand, or are such actions pending with respect to your DEA certification? (If applicable).		
3.	Have your hospital privileges at or with a healthcare organization (e.g. medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payor, medical society, professional association, medical school facility position or other health delivery entity or system) ever been denied, restricted, limited, suspended, revoked, not renewed; have disciplinary proceedings ever been instituted against you; or are any of these actions now pending? (If applicable).		
4.	Have you ever surrendered clinical privileges, terminated contractual participation or employment, or resigned from any medical/healthcare organization (e.g. medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payor, medical society, professional association, medical school facility position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or in return for such an investigation not being conducted, or is any such action pending?		
5.	Has your participation in Medicare, Medicaid, or other government program ever been denied, limited, suspended, revoked, not renewed, or subject to probationary conditions; or, to the best of your knowledge, have you ever been under investigation by a regulatory agency?		
6.	Have you ever been convicted of a felony or do you have any felony or misdemeanor charges pending other than traffic offenses; or history of crimes against children?		
7.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, limited, or not renewed, or is any such action pending?		
8.	Have you ever been denied certification/recertification, or has your eligibility status changed with respect to certification/recertification by a specialty or governing board?		
<b>HEALTH STATUS</b>			
9.	Are you <b>unable</b> to perform all of the professional services for which you have been licensed with or without reasonable accommodation, according to all accepted standards of professional performance and without posing a direct threat to your safety or the safety of patients?		
10.	Do you now have, or have you had, a chemical dependency or any mental health problem(s) or are you currently receiving professional care for substance abuse or any similar treatment?		
11.	Are you currently taking any medications that may affect either your clinical judgment or motor skills?		
12.	Are you using drugs illegally?		

Practitioner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (STAMPED SIGNATURE IS NOT ACCEPTED)

Printed Name: \_\_\_\_\_