MICHIGAN STATE UNIVERSITY | College of Human Medicine

# APPLICATION FOR NON-PREFIX FACULTY APPOINTMENT

Faculty who are granted an appointment in the Clinical/Adjunct appointment system with a "non-prefix" rank must be deeply involved in the college as evidenced by meeting at least one of the eligibility criteria listed below. Appointment length varies but is generally for three years and is renewable as long as the eligibility requirements continue to be met. Approval by the department chair and the dean's office is required.

**ELIGIBILITY CRITERIA**:
***Indicate which of the following qualifies you for a non-prefix appointment:***

☐ I have an official administrative position in the college (e.g., Clerkship Director, Course Director, etc.) Official administrative positions in the college are designated as such by the dean's office.

*My role:* _____

☐ I am paid by a College of Human Medicine-affiliated or College of Human Medicine-sponsored residency as core faculty or administrator (e.g., Residency Director). "Core faculty" means a significant amount of your effort is devoted to teaching/precepting, and you are paid by the residency program or clinical entity specifically for your teaching role.

*My role:* _____

☐ I am engaged in a meaningful, collaborative research relationship with the College of Human Medicine as adjudicated by the college Senior Associate Dean for Research.

*MSU department or faculty member I am working with:* _____

**COMMUNITY AFFILIATION**:

□ Flint □ Grand Rapids □ Lansing □ Midland □ Traverse City □ Upper Peninsula □ Southeast Michigan

**DEPARTMENT:** I am requesting appointment in the department(s) of:

□ Emergency Medicine
□ Family Medicine
□ Medicine
□ Obstetrics, Gynecology & Reproductive Biology
□ Pediatrics & Human Development
□ Psychiatry
□ Radiology
□ Surgery
□ Translational Science & Molecular Medicine
□ *Uncertain – Please advise*

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**NAME: FIRST** _____ **MIDDLE** _____ **LAST** _____

**SOCIAL SECURITY #:** _____ **DATE OF BIRTH:** _____ **GENDER:** □ Male □ Female

**CITIZENSHIP:** □ U.S. Citizen □ Non Resident Alien □ Non-Citizen Nat'l of U.S. □ Permanent Resident

**TYPE OF VISA:** _____ **COUNTRY OF CITIZENSHIP:** _____

**ETHNICITY/RACE:** □ Of Hispanic or Latino Origin □ Not of Hispanic or Latino Origin

***Please check at least one status as well as all that apply:*** □ American Indian or Alaskan Native □ Asian □ Black or African American □ Hawaiian/Pacific Islander □ White

**PREFERRED MAILING ADDRESS:** □ **Home** □ **Office** □ **Other**

*(Street/City/State/Zip):*_____

**SECONDARY MAILING ADDRESS:** □ **Home** □ **Office** □ **Other**

*(Street/City/State/Zip):*_____

**HOME PHONE:** _____ **CELL PHONE:** _____ **BUSINESS PHONE:** _____

**E-MAIL:** _____

**EMERGENCY CONTACT INFORMATION:**

**NAME:** First _____ Last _____ Phone _____

Address_____ City _____ State _____ Zip _____

**MEDICAL PRACTICE NAME:** _____

ADDRESS: _____

**GROUP AFFILIATION (***e.g., SHMG, Advantage Health***):** _____

ADDRESS: _____

**EDUCATION:**

**Degree 1:**

Most Relevant Highest Degree _____

Major Field of Study _____

School (Institution) _____

Date Degree Received _____

**Degree 2:**

Most Relevant Highest Degree _____

Major Field of Study _____

School (Institution) _____

Date Degree Received _____

**POSTGRADUATE TRAINING:**

**INTERNSHIP**: Institution _____ Dates _____

**RESIDENCY:** Specialty _____ Institution _____ Dates _____

Specialty _____ Institution _____ Dates _____

**FELLOWSHIP**: Specialty _____ Institution _____ Dates _____

**NATIONAL PROVIDER ID** _____

**MEDICAL LICENSE:**

License Number _____ State _____ Date Issued _____

License Pending?_____ (indicate reason, e.g., new resident or out-of-state)

**BOARD ELIGIBILITY/ CERTIFICATIONS:**

Certified? □ Yes □ No Certified Specialty _____ Date Issued _____

Other Specialty _____

If not board-certified, are you board-eligible? □ Yes □ No Eligible Specialty _____

**PRIVILEGES:**

Hospital _____ City/State _____

Hospital _____ City/State _____

**PREVIOUS ACADEMIC EXPERIENCE:**

Institution _____ Position _____ Years _____

Institution _____ Position _____ Years _____

**EXPECTATIONS:**

***Please check all of the following, acknowledging your agreement with the expectations of this appointment:***

- ☐ I am able to demonstrate significant effort on MSU-related activities (generally considered to be at least 20%) across the three areas of teaching, scholarly productivity/research, and institutional service, as outlined in the CHM promotion criteria.
- ☐ I agree to make continuing meaningful contributions to the instructional mission of CHM.
- ☐ I have been made aware of the promotion criteria and the expectation that I will work toward academic promotion.

**ANY RELATIVE EMPLOYED BY MSU?** □ No □ Yes *(If yes, name, relationship, title, department)

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**DISCLOSURE OF SIGNIFICANT FINANCIAL INTERESTS RELATED TO MSU**

Do you, your spouse, domestic partner, dependent children and/or other dependents residing with you have any financial interest related to your MSU responsibilities? □ Yes □ No
If "Yes" please list the name of entities related to your MSU responsibilities in which you have a personal financial interest.

_____

_____

_____

NOTE: You are not required to disclose travel that is reimbursed or sponsored by any of the following U.S.entities: government agencies; institutions of higher education; teaching hospitals or medical centers; or research institutes affiliated with a U.S. institution of higher education.

**PERSONAL CERTIFICATION: I understand that it is my responsibility to send an updated COI Disclosure Form within thirty days of acquiring any new significant financial interest related to my responsibilities above or if the details/relationships with disclosed entities change.**

***PLEASE INCLUDE A CURRENT CURRICULUM VITAE WITH THIS APPLICATION***

***To the best of my knowledge, I certify that all information provided in this application is correct.***

**Signature:** _____ **Date:** _____