EMORY

THE EMORY PHYSICIAN ASSISTANT POST-GRADUATE CARDIOTHORACIC SURGICAL RESIDENCY PROGRAM

APPLICATION FOR ADMISSIONS

Instructions:

1. **Complete application in its entirety and submit to:**

Patty Joy
Administrative Assistant
Emory PA Post-Graduate Cardiothoracic Surgical Residency Program
Emory University Hospital Midtown
550 Peachtree Street
6th Floor Medical Office Tower
Atlanta, GA 30308
Email: patty.joy@emoryhealthcare.org

2. **Include a 1-page typed Personal Statement describing yourself, your background, and why you desire a career in Cardiothoracic Surgery. Include as an email attachment to this application.**
3. **Include Passport photo and a copy of current CV as email attachments to this application.**
4. **Submit hard or scanned copies of ACLS & BLS cards.**
5. **Submit transcripts from your PA program to the Program Director in a sealed envelope with the author's signature across the seal of the envelope.**
6. **Submit three letters of professional recommendation on behalf of your application to the program. May be sent via email directly from the reference to Ms Patty Joy at patty.joy@emoryhealthcare.org.**
7. **Program Calender:**

Event	January Start	August Start
Application Deadline	June 15th	January 15th
Interview Notification	July 1st	February 1st
Interview Dates	Last Week of July	Last Week of February
Selection Notification	2nd Week of August	2nd Week of March
Commitment to Program	September 1st	April 1st

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EMORY
Physician Assistant Post-Graduate
Cardiothoracic Surgical Residency Program

APPLICANT INFORMATION			
Last Name	First	M.I.	Date
Street Address		Apartment/Unit #	
City	State	ZIP	
Phone	E-mail Address		
Date of Birth	Social Security No.	Gender Male ☐	Female ☐

Are you a citizen of the United States?	YES ☐	NO ☐	If no, are you authorized to work in the U.S.?	YES ☐ NO ☐
Have you ever worked for Emory?	YES ☐	NO ☐	If so, when	
Have you ever been convicted of a felony?	YES ☐	NO ☐	If yes,	

EDUCATION				
High School			Address	
From	To	Date of Graduation		
College			Address	
From	To	Date of Graduation	Degree	
PA Program			Address	
From	To	Date of Graduation	Degree	NCCPA Number

REFERENCES	
List three professional references. Each should submit a letter of support for your application ***(One letter must be from your Program Director)***	
Full Name	Relationship
Company	Phone ( )
Address	
Full Name	Relationship
Company	Phone ( )
Address	
Full Name	Relationship
Company	Phone ( )
Address	

PREVIOUS EMPLOYMENT AND/OR MEDICAL EXPERIENCE: Include all adult employment experiences, accounting for any and all gaps in employment		
Company		Phone
Address		Supervisor
Job Title		
Responsibilities		
From To	Reason for Leaving	
Company		Phone ( )
Address		Supervisor
Job Title		
Responsibilities		
From To	Reason for Leaving	
Company		Phone ( )
Address		Supervisor
Job Title		
Responsibilities		
From To	Reason for Leaving	

MILITARY SERVICE	
Branch	From To
Rank at Discharge	Type of Discharge
If other than honorable, explain	

DISCLAIMER AND SIGNATURE

Authorization & Verification Agreement

I hereby authorize Emory Healthcare and The Emory Clinic, Inc., the medical staff(s) at Emory Healthcare and The Emory Clinic, Inc., 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 Emory Healthcare and The Emory Clinic, Inc., the medical staff(s) at Emory Healthcare and The Emory Clinic, Inc., 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 Emory Healthcare and The Emory Clinic, Inc., or medical staff(s) at Emory Healthcare and The Emory Clinic, Inc., 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 Emory Healthcare and The Emory Clinic, Inc..

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 Emory Healthcare and The Emory Clinic, Inc., or a component Emory Healthcare and The Emory Clinic, Inc., is a participating entity, subject to Emory Healthcare and The Emory Clinic, Inc., 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.

Electronic Signature

Date

SUBMIT