**faculty appointment Application for clinical departments**

**Instructor/Assistant Professor\***

|  |  |
| --- | --- |
| **Date:** | Click or tap here to enter text. |
| **Full Name and Degree:** | Click or tap here to enter text. |
| **Preferred Mailing Address:**  **Number and Street** | Click or tap here to enter text. |
| **Apt Number if applicable** |  |
| **City** | Click or tap here to enter text. |
| **State** | Click or tap here to enter text. |
| **Zip** | Click or tap here to enter text. |
| **Work Phone #** | Click or tap here to enter text. |
| **Cell Phone #** | Click or tap here to enter text. |
| **Preferred E-mail Address** | Click or tap here to enter text. |
| **Department** | Click or tap here to enter text. |
| **Academic Campus *(If applicable)*** | Click or tap here to enter text. |
| **Requested Rank *(highlight or circle)*** | **Assistant Professor**  **Instructor** |

***\*Physicians must be board certified for the rank of Assistant Professor; non-physicians must include 2 letters of support with their Assistant Professor applications.***

**Medical School:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Institution** | **Location** | **Degree Awarded** | **Year Degree Awarded** |
|  |  |  |  |
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**Internships, Residencies and Fellowships:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Institution** | **Location** | **Specialty and type of training** | **Date of Completion** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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**Licensure: (COMPLETE ALL FIELDS)**

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| --- | --- | --- | --- |
| **State** | **License Number** | **Initial Licensing Date** | **Expiration Date** |
|  |  |  |  |
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**Board Certification: (Required for the rank of Assistant Professor – COMPLETE ALL FIELDS)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Certifying Board** | **Board Certification Number** | **Initial Certification Date** | **Expiration Date** |
|  |  |  |  |
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**Employment History:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Institution** | **Location** | **Title** | **Dates** |
|  |  |  |  |
|  |  |  |  |
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**Faculty Appointment History:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Institution and Location** | **Academic Rank** | **Effective Date** | **End Date (if applicable)** |
|  |  |  |  |
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**Other Information (i.e. selected publications or presentations, memberships and offices in professional societies, educational activities, etc.):**

***To be completed by the Academic Campus Clinical Department Chair (or responsible party as designated by DME/ Regional Associate Dean) at the Academic Campus:***

I am supportive of a faculty appointment for at the rank of in the department of

***To be completed by the Director of Medical Education or Regional Associate Dean at the Academic Campus:***

I certify that. :

* Is in good standing at
* A current member of the medical staff
* Fulfills the requirements for a faculty appointment at  **Level I  Level II (check one)**

I am also acknowledging my support and the appropriateness of a faculty appointment at Drexel University’s College of Medicine.

|  |  |
| --- | --- |
| **Level I** | * Formal classroom teaching of students, residents, grad students, fellows, faculty, other health care professionals and staff * 1-2 learners per rotation/per year * Evaluate students, residents and fellows * Mentorship of students, residents, grad fellows, fellows, faculty, other health care professionals and staff * Rounding * Supervision * Case Conference * Participation in medical school and affiliate educational committees |
| **Level II** | * Rounding * Supervision * Other teaching activities * Evaluate students, residents and fellows * 1-2 learners for at least 3-4 rotations per year |

|  |  |
| --- | --- |
| **Print or Type Name of Academic Campus Clinical Department Chair** |  |
| **Signature** |  |
| **Date** |  |

|  |  |
| --- | --- |
| **Print or Type Name of DME/Regional Associate Dean** |  |
| **Signature** |  |
| **Date** |  |

**Please e-mail completed appointment applications signed by the Academic Campus Clinical Department Chair and DME, along with the applicant’s CV, to the Office of Faculty at** [**COM.FAFD@drexel.edu**](mailto:COM.FAFD@drexel.edu) **at Drexel University College of Medicine.**

**Submitted by:**

|  |  |
| --- | --- |
| **Name** | Click or tap here to enter text. |
| **Date** |  |
| **E-mail** | Click or tap here to enter text. |
| **Phone number** | Click or tap here to enter text. |

***To be completed by the DUCOM Academic Chair:***

I am supportive of a faculty appointment for. at the rank of

in the department of

|  |  |
| --- | --- |
| **Print or Type Name of Academic Chair** |  |
| **Signature** |  |
| **Date** |  |

**Please e-mail completed appointment application signed by the DUCOM Academic Chair to the Office of Faculty at** [**COM.FAFD@drexel.edu**](mailto:COM.FAFD@drexel.edu)

**Submitted by:**

|  |  |
| --- | --- |
| **Name** | Click or tap here to enter text. |
| **Date** |  |
| **E-mail** | Click or tap here to enter text. |
| **Phone number** | Click or tap here to enter text. |

***\*Revised August 4, 2022***