**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***

**Medical School:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Institution** | **Location** | **Degree Awarded** | **Year Degree Awarded** |
|  |  |  |  |
|  |  |  |  |

**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)**

|  |  |  |  |
| --- | --- | --- | --- |
| **State** | **License Number** | **Initial Licensing Date** | **Expiration Date** |
|  |  |  |  |
|  |  |  |  |

**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** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**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 Campus Department Chair (or responsible party as designated by DME/Regional Dean):***

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

|  |  |
| --- | --- |
| **Print or Type Name of responsible party** |  |
| **Signature** |  |
| **Date** |  |

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

I certify that Dr. :

* Is in good standing at
* A current member of the medical staff

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

|  |  |
| --- | --- |
| **Print or Type Name of DME** |  |
| **Signature** |  |
| **Date** |  |

**Please e-mail completed appointment applications signed by the Campus Chair and DME to the Academic Department Chair 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 Dr. at the rank of in the department of

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

**Please e-mail completed appointment applications signed by the Campus Chair, DME and Academic Department Chair to the Office of Faculty Affairs at** **COM.FAFD@drexel.edu**

Submitted by:

|  |  |
| --- | --- |
| Name |  |
| Date |  |
| E-mail |  |
| Phone number |  |