Resident Name:       Program:

**DIO Transfer Approval Packet**

**Process for Accepting Transferring House Officers from other Institutions**

According to ACGME Institutional Requirements, the institution and our ACGME-accredited programs are at risk for loss of accreditation if non-eligible residents are accepted into our training programs. For that reason, when applicants for positions are under consideration via transfer, the GME Office must be included in the process. The process follows the sequence:

1. Application is made by an individual to transfer from another ACGME-accredited program.
2. The receiving program reviews supporting documentation. If the applicant is considered suited to the position, the program obtains further information as appropriate and completes the checklist below.
3. The completed checklist is sent to the GME Office for review.
4. The GME Office will review the information and communicate approval/non-approval to the program within three days of receipt of a completed checklist.
5. If the GME Office approves, the position may be officially offered to the applicant.

**TRANSFERRING HOUSE OFFICERS FROM OTHER INSTITUTIONS**

 DIO Transfer Approval Checklist

 DIO Transfer Approval Packet

 DIO Transfer Approval Packet Program Director Questionnaire

 \*\* **This form must be completed by each program that the applicant has attended.**

 Release Data to LSU Form

 Curriculum Vitae

 Original or Certified Copy of Diploma

 Dean’s Letter

 Residency Diploma (if applicable)

 Fellowship Diploma (if applicable)

 ECFMG Certificate (if applicable)

 Copy of All Licenses or Permits

 DEA (if applicable)

 USMLE Scores (All)

 Milestones Assessments from the Prior Training Program

Resident Name:       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Program:       \_\_\_\_\_\_\_\_\_\_\_\_\_

**Instructions: LSU Program Director must review and verify the entire submission packet. Place an “X” in the box to verify completion.**

|  |  |  |
| --- | --- | --- |
| 1. | Curriculum Vitae Reviewed by Program Director | [ ]  |
| 2. | All parts of the Application & Applicant Attestation reviewed by Program Director. (Any “yes” answers explained to program satisfaction? | [ ]  |
| 3. | Reviewed by Program Director:[ ]  Original or Certified Copy of Diploma[ ]  Dean’s Letter[ ]  Residency Diploma (if applicable)[ ]  Fellowship Diploma (if applicable)[ ]  ECFMG Certificate (if applicable)[ ]  Copy of All Licenses or Permits[ ]  DEA (if applicable)[ ]  USMLE Scores (All)[ ]  Milestones Assessments from the Prior Training Program |  |
| 4. | Training Dates Verified? Any gaps explained to program satisfaction? | [ ]  |
| 5. | ACGME required letter and program questionnaire from each program? | [ ]  |
| 6. | Licensure verified at State Website? No actions/limitations? | [ ]  |
| 7. | Copies of USMLE scores verified, reviewed?  | [ ]  |
| 8. | Applicant has all USMLE Steps passed necessary for licensure? | [ ]  |

Please submit any comments regarding the above required documentation that the program would like to explain to the GME Office

Date Submitted to the GME Office for Review:

Approved by the GME Office

Not Approved by the GME Office

Comments:

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

DIO Signature Date

**DIO Transfer Approval Packet**

**PROGRAM DIRECTOR QUESTIONNAIRE**

**LSU SCHOOL OF MEDICINE - GME OFFICE**

**INSTRUCTIONS: This form must be completed by the Program Directors of each program that the applicant has attended.**

 has applied to the LSU School of Medicine – New Orleans training program. In addition to the ACGME required letter from his current program which must verify previous educational experiences and include a statement regarding the performance evaluations of the transferring applicant, including a milestones assessment of competencies in the six areas in Section IVB of the ACGME Institutional Requirements, we request answers to the following questions before proceeding to consider the applicant.

Did the applicant ever have any of the following (please check Yes or No)?

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **Remediation** | [ ]  | [ ]  |
| **Probation** | [ ]  | [ ]  |
| **Suspension** | [ ]  | [ ]  |
| **Non Reappointment** | [ ]  | [ ]  |
| **Non Promotion** | [ ]  | [ ]  |
| **Termination** | [ ]  | [ ]  |
| **Leaving program in Lieu of Disciplinary Action** | [ ]  | [ ]  |
| **Incompletion or extension of training** | [ ]  | [ ]  |
| **Other: please explain**   | [ ]  | [ ]  |

If Yes has been answered to any of the above items, please attach an explanation.

Please list training dates for which credit towards any applicable board will be given:

**A signed release that allows you to answer these questions and relate any other relevant material we should consider in this application has been completed.**

Should you have any questions regarding this matter please contact: Lee Engel, MD, Associate Dean for Academic Affairs and DIO, LSU School of Medicine – New Orleans (LEngel@lsuhsc.edu or 504-568-4006).

Director Name: Email:

Phone: Signature:

**DIO Transfer Approval Packet**

**TRANSFER FROM OTHER INSTITUTION**

**LSU SCHOOL OF MEDICINE – GME OFFICE**

**PLEASE PRINT LEGIBLY OR TYPE**

 ***(Circle one):***

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ House Officer Level \_\_\_\_\_\_\_\_ Residency or Fellowship

  ***(Level you will be in July****)*

Training Program Name/City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***(State Combined name if is combined Program & Fellowship name if fellowship****)*

Begin Date **(Month/Day/Year):** \_\_\_\_\_\_\_\_\_\_\_\_ Expected End Date **(Month/Day/Year):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 ***(Last) (First) (Middle***)

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***(Street) (City) (State) (Zip****)*

Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_Immigration Status: U.S. Citizen \_\_ Permanent Resident \_\_ J-1 Visa \_\_

Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Citizenship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Place of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: \_\_\_ Male \_\_\_ Female Marital Status: S M W D Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: ***(Please check one)***

American Native\_\_\_\_ Asian or Pacific Islander \_\_\_\_\_ Hispanic \_\_\_\_\_\_ White \_\_\_\_\_\_ Black\_\_\_\_\_\_\_\_

List Person to Contact in case of Emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EDUCATION:**

**Medical School**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City,State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree & Date Received:\_\_\_\_\_\_\_\_\_

**Dental School**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City,State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree & Date Received:\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FMGEM, ECFMG or NBMEE Number and Date**:

Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LA Medical License #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **License or Permit Expiration Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no License, What type of Permit? \_\_\_\_Intern \_\_\_PGY2 \_\_\_GETP \_\_\_Interim \_\_\_Temp \_\_\_\_Other

**If Other**, What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Applicant Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POST GRADUATE TRAINING**

**A continuous and inclusive list of internships, residencies, fellowships, staff positions, leave of absences, etc must be provided from Medical School graduation through the current internship, residency or fellowship. Account for All Time in Chronological Order.**

Month/Day/Year Started:\_\_\_\_\_\_\_\_\_\_\_\_ Month/Day/Year Ended\_\_\_\_\_\_\_\_\_\_\_\_ Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital/School & Program:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City and State & Country if not U.S.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Month/Day/Year Started:\_\_\_\_\_\_\_\_\_\_\_\_ Month/Day/Year Ended\_\_\_\_\_\_\_\_\_\_\_\_ Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital/School & Program:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City and State & Country if not U.S.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Month/Day/Year Started:\_\_\_\_\_\_\_\_\_\_\_\_ Month/Day/Year Ended\_\_\_\_\_\_\_\_\_\_\_\_ Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital/School & Program:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City and State & Country if not U.S.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Month/Day/Year Started:\_\_\_\_\_\_\_\_\_\_\_\_ Month/Day/Year Ended\_\_\_\_\_\_\_\_\_\_\_\_ Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital/School & Program:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City and State & Country if not U.S.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Month/Day/Year Started:\_\_\_\_\_\_\_\_\_\_\_\_ Month/Day/Year Ended\_\_\_\_\_\_\_\_\_\_\_\_ Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital/School & Program:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City and State & Country if not U.S.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Explain any gaps in the above longer than 1 month – use additional pages if necessary.**

**USMLE Scores:**

|  |  |  |
| --- | --- | --- |
|  | Score | Number of Attempts |
| Step 1 |  |  |
| Step 2 CK |  |  |
| Step 2 CS |  |  |
| Step 3 |  |  |

**Applicant Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Answer the following questions (Yes answers must be explained. Attach legible explanation)**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Yes | No |
| 1. | Were you the subject of disciplinary action, placed on academic probation, or asked to undergo additional training or remediation during your professional training (as a student, intern, resident, fellow, or other trainee)?  |  |  |
| 2. | Was your professional training program extended for any reason? |  |  |
| 3. | Did you leave any professional training program as defined above before completion?  |  |  |
| 4. | Did you surrender or fail to renew staff or clinical privileges at any hospital, clinic, or other health care entity In lieu of investigation, while under investigation or while you were the subject of disciplinary proceedings?  |  |  |
| 5. | For **each** program you attended, have you ever had: (write N/A by each that is not applicable or mark Y for those that occurred)

|  |
| --- |
| Remediation |
| Probation |
| Suspension |
| Non Reappointment |
| Non Promotion |
| Termination |
| Leaving/Left program in lieu of disciplinary action |
| Any other disciplinary activities, If yes, please explain |

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| 6.. | Have you failed a professional licensure or certification examination (any step/part of FLEX, USMLE, NBME, NBOME, COMPLEX-USA, SPEX/COMVEX-USA or PMLexis)? |  |  |
| 7. | Have you surrendered your state or federal controlled substances permit or registration? |  |  |

**Explain any “Yes” answers above-use additional pages if necessary**

**Why are you transferring programs?**

**Applicant Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Practice History and Non-Professional Activity (Do NOT include Training).**

**Account for ALL time not specified on previous pages, in chronological order, from Medical School to the present,**

**(Include time off to travel, care for relatives, leave of absences, etc).**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| From Mo/Day/Yr | To Mo/Day/Yr | City | State or Country | Employer / Practice Setting(Clinic, Hosp., Solo/Group, Etc.) | Specialty or Activity  |
|  |  |  |  |  |  |
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**Please Attach Copies of the Following:**

 **Curriculum Vitae**

**Original or Certified Copy of Diploma**

**Dean’s Letter**

**Residency Diploma (if applicable)**

**Fellowship Diploma (if applicable)**

 **ECFMG Certificate (if applicable)**

 **Copy of All Current Licenses or Permits**

 **DEA Licensure**

 **USMLE Scores (All)**

**Milestones Assessments from the Prior Training Program**

**I attest that the above information is complete and accurate and I understand any misrepresentations are grounds for immediate withdrawal of any offer to employee or immediate termination if discovered after my employment begins**.

**Applicant Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_