MORRIS
Cardiovascular and Risk Reduction Center

MEDICAL PROFESSIONALS OUTREACH

CANDIDATE INFORMATION

First Name _____ M.I. ___ Last Name _____

Permanent Address _____

City _____ State _____ Zip Code _____

Email Address (active)_____

Phone Number _____ ***Circle:*** Home/Work/Cell

Alternative Number_____ ***Circle:*** Home/Work/Cell

HIGHEST EDUCATION: _____

CERTIFICATIONS*/LICENSURE*: _____

_____

** Please denote years certified/licensed for each*

☐ All certifications/licensures are current. *If not, explain:* _____

Estimated total patient contact hours, to date: _____

Requested Morris Cardio contact hours: _____

Available start and end dates _____

HOURS AND AVAILABILITY:

MON _____
TUES _____
WED _____
THURS _____
FRI _____
SAT _____
SUN _____

☐ My outreach hours are credited towards an academic degree or certification

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OBJECTIVES

Briefly explain why you would like to participate in the program

_____

_____

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_____

Briefly explain why you feel you demonstrate the appropriate leadership skills and interpersonal skills to qualify for this position

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I would like to provide the following services:

_____

_____

_____

_____

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_____

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DISCLOSURE:

If selected as a candidate for the Medical Professionals Outreach Program, I agree to demonstrate medical and interpersonal integrity with every patient and will not engage in any behaviors that may potentially compromise my professional certifications/licensures or the values of Morris Cardiovascular and Risk Reduction Center. I also understand any information that is made available to me regarding any and all patients and/or staff members is confidential under HIPPA international rules and regulations.

☐ **I certify all the information is correct to the best of my ability**

☐ **I have attached my professional resume**

SIGNATURE:

I verify that all information is accurate to my knowledge and upon request I will provide the supplemental documents accordingly.

_____ _____

Signature Date

Thank You for Applying!

FOR OFFICE USE ONLY:

_____

Reviewed