

UMDNJ PAID & VOLUNTEER FACULTY PERSONAL DATA

Complete both pages of this form and sign at the bottom of page 2.

Please select an Account No. (for HR use only)

473 – Newark Paid Faculty

482 - Newark Volunteer Faculty

474 – N. Bruns./Pisc. Paid Faculty

483 - N. Bruns./Pisc. Volunteer Faculty

475 – Stratford/Camden Paid Faculty

484 – Stratford/Camden Volunteer Faculty

First Name

Last Name

Date of Birth

Social Security No.

Other Names You Have Used: _____

Please list all addresses for the past ten years. If more than three, please use the reverse side of this form.

Address

City

State

Zip

Dates: From - To

1) _____ - _____

2) _____ - _____

3) _____ - _____

Current/Previous Employment:

1) _____
Most Recent Employer Full Street Address, City, State Phone Number

Your Title

Supervisor's Name & Phone Number

Dates Employed: From - To

2) _____
Next Employer Full Street Address, City, State Phone Number

Your Title

Supervisor's Name & Phone Number

Dates Employed: From - To

3) _____
Next Employer Full Street Address, City, State Phone Number

Your Title

Supervisor's Name & Phone Number

Dates Employed: From - To

MAY WE CONTACT YOUR CURRENT EMPLOYER? YES () NO ()

Please list the highest education completed:

Name of School or University

Address

Degree

Date Awarded

Name Under Which Attended

Please list all professional licenses and certifications, including those held in more than one state:

Type of License/Certification: _____ Number : _____ State issued: _____

Type of License/Certification: _____ Number : _____ State issued: _____

Type of License/Certification: _____ Number : _____ State issued: _____

Have you ever been a subject of an investigation into an allegation of research misconduct (research misconduct is defined as fabrication and/or falsification of data or plagiarism)? If yes, when was such investigation conducted and at which institution? (Please use a separate sheet to explain) _____ Yes _____ No

Print Name _____ SS# _____

LIABILITY CLAIMS INFORMATION - FOR PAID FULL-TIME & PAID PART-TIME CLINICAL FACULTY ONLY:

Please document your professional liability loss experience for the most recent five-year period by attaching documentation prepared by your previous insurance carrier(s) and/or your prior employer(s). The documentation should include the following information:

1. Whether or not any professional liability claims or law suits were brought against you in the past five years.
2. Any settlements made on your behalf and/or any judgments entered against you within the past five years.
3. A description of the material facts applicable to the claims and suits referenced in points one (1) and two (2), as well as the amount of any settlements/judgments made on your behalf.

Note: You may be requested to provide additional information regarding claims or suits resulting in settlements or judgments, including relevant records or descriptive information which may be available from your defense counsel or insurer.

**APPLICANT'S AUTHORIZATION TO
RELEASE INFORMATION**

I understand and agree that, as a candidate for appointment to UMDNJ, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.

I authorize UMDNJ and its agents to consult with employers, educational institutions, members of hospital medical staffs, professional liability carriers and any other persons or entities to obtain information about me, and I authorize any and all such persons and entities to release any information about me that may be relevant to an evaluation of my qualifications. This information may include confidential or privileged information, such as information about disciplinary actions and National Practitioner Data Bank (NPDB) reports. I hereby release UMDNJ, its affiliated entities, employees and agents from any and all liability for requesting information and acting based on such information. I also release from liability any individuals and entities that in good faith provide such information to UMDNJ.

I understand that any misstatement or omission in this form may constitute grounds for denial of this appointment, discipline or termination. I agree that if any material changes occur affecting my professional status or qualifications, or if I am notified by the National Practitioner Data Bank of any adverse action against me, or if I am convicted or plead guilty or no contest to any felony or misdemeanor, it is my obligation to immediately notify UMDNJ.

I certify that the information provided on or with this form is true and complete to the best of my knowledge. I certify that I have fully read and understand the above statements and agree to them.

APPLICANT SIGNATURE: _____
(Signature stamp not accepted)

DATE: _____