DEPARTMENT OF MEDICINE FACULTY DEMOGRAPHIC CHECKLIST

New Hospital / Academic Appointment, Life Number Request and Managed Care Insurance Enrollment Form

LAST NAME, FIRST NAME:	
CREDENTIALS (MD, DO, PHD, Etc.):	
START DATE:	
LIFE NUMBER ***(if previously or currently employed):***	
STATUS (FULL TIME, PART TIME OR PER DIEM)	
SALARIED OR VOLUNTARY:	
INCREMENTAL OR REPLACEMENT: ***(If replacement, provide current/past faculty name)***	
ACADEMIC TITLE:	
EMAIL ADDRESS ***(Personal email preferred for new salaried appointments).***	
PRIMARY SITE:	
MEDICINE DIVISION: **SECONDARY DEPARTMENT?:**	
DATE OF BIRTH:	
SOCIAL SECURITY #:	
CONTACT#:	
NPI#:	
GENDER:	
USA CITIZEN OR PERMANENT RESIDENT (SELECT ONE):	
VISA REQUIRED (YES OR NO) *If yes, contact the International Personnel Office*	
COUNTRY OF BIRTH:	
HOME ADDRESS:	
PATIENT SERVICE ADDRESS(ES):	