

**MICHIGAN STATE**  
**UNIVERSITY**  
**COLLEGE OF HUMAN MEDICINE**

**APPLICATION FOR NON-PREFIX FACULTY APPOINTMENT**

Faculty who are not directly employed by CHM but **are deeply involved in the college and making significant contributions regardless of the campus**, are eligible for a Fixed Term Non-Prefix faculty appointment if they meet the eligibility and expectation requirements. Appointment length varies but is generally for 3 years and is renewable.

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**ELIGIBILITY:**

In addition to being **deeply involved in the college and making significant contributions to CHM**, indicate which of the following criteria qualify you for a non-prefix appointment (check one):

- Administrative position in the college (e.g., clerkship director, course director, etc.)
- Paid faculty or administrator in a CHM affiliated residency
- Meaningful collaborative research relationship as adjudicated by the CHM Associate Dean for Research

**EXPECTATIONS:**

Please check each of the following, acknowledging your understanding of these appointment expectations:

- I will receive an annual review.
  - I will be strongly encouraged to work toward promotion.
  - I will be expected to make meaningful contributions to the instructional mission.
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*Please type or print all information legibly. Incomplete applications or missing information may delay appointment!*

- CHM Community Affiliation:**
- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Flint        | <input type="checkbox"/> Lansing         |
| <input type="checkbox"/> Grand Rapids | <input type="checkbox"/> Saginaw         |
| <input type="checkbox"/> Kalamazoo    | <input type="checkbox"/> Traverse City   |
|                                       | <input type="checkbox"/> Upper Peninsula |
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**I am requesting appointment in the Department of:**

- |  |   |
|--|---|
| <input type="checkbox"/> Family Medicine (EL)                | <input type="checkbox"/> Psychiatry (EL)                        |
| <input type="checkbox"/> Medicine (EL)                       | <input type="checkbox"/> Surgery (EL)                           |
| <input type="checkbox"/> Neurology/Ophthalmology (EL)        | <input type="checkbox"/> Obstetrics, Gynecology & Repro Biology |
| <input type="checkbox"/> Pediatrics & Human Development (EL) | <input type="checkbox"/> Other (specify): _____                 |
| <input type="checkbox"/> Radiology (EL)                      | <input type="checkbox"/> Uncertain – Please assist/advise       |
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**NAME** (*last, first, middle initial*): \_\_\_\_\_

**PREFERRED MAILING ADDRESS:**  Home  Office  Other

(*Street/City/State/Zip*): \_\_\_\_\_

**SECONDARY MAILING ADDRESS:**  Home  Office  Other

(*Street/City/State/Zip*): \_\_\_\_\_

**BUSINESS PHONE:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **HOME PHONE:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**CELL:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **FAX:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **E-MAIL:** \_\_\_\_\_

**PRACTICE GROUP AFFILIATION** (*name and address if applicable*):

(*Practice Name/Street/City/State/Zip*): \_\_\_\_\_

**SOCIAL SECURITY NUMBER:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ **GENDER:**  Male  Female

DATE OF BIRTH: \_\_\_\_\_ U.S. CITIZEN?  Yes  No

IF NOT US CITIZEN:  Permanent Resident  Foreign National Type of Visa \_\_\_\_\_

Country of Citizenship: \_\_\_\_\_

ETHNICITY:  Black  Asian/Pacific Islander  Hispanic  Amer. Indian/Alaskan  Caucasian

ANY RELATIVE EMPLOYED BY MSU?  No  Yes (If yes, name, relationship, title, department):

(Name/Relationship/Title/Dept): \_\_\_\_\_

Office use only: MSU Conflict of Interest form is:  Attached  On File (previously submitted)

DO YOU CURRENTLY HAVE AN MSU APPOINTMENT?  No  Yes If yes, rank: \_\_\_\_\_ Dept: \_\_\_\_\_

ARE YOU A CHM ALUM?  Yes  No

EDUCATION:	Degree Earned	Major Field of Study	Institution	Year
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

**POSTGRADUATE TRAINING:**

INTERNSHIP: Institution \_\_\_\_\_ Dates \_\_\_\_\_

RESIDENCY: Specialty \_\_\_\_\_ Institution \_\_\_\_\_ Dates \_\_\_\_\_  
Specialty \_\_\_\_\_ Institution \_\_\_\_\_ Dates \_\_\_\_\_

FELLOWSHIP: Specialty \_\_\_\_\_ Institution \_\_\_\_\_ Dates \_\_\_\_\_

LICENSES: License Number \_\_\_\_\_ State \_\_\_\_\_ Date Issued: \_\_\_\_\_  
License Number \_\_\_\_\_ State \_\_\_\_\_ Date Issued: \_\_\_\_\_  
License Pending?  (indicate reason, e.g., new resident or out-of-state)

**BOARD ELIGIBILITY/ CERTIFICATIONS**

Certified?  Yes  No Specialty \_\_\_\_\_ Date Issued: \_\_\_\_\_  
Certified?  Yes  No Specialty \_\_\_\_\_ Date Issued: \_\_\_\_\_  
Eligible?  Yes  No Specialty \_\_\_\_\_ Date Issued: \_\_\_\_\_

PRIVILEGES: Hospital \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Hospital \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Hospital \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**PREVIOUS UNIVERSITY EXPERIENCE**

Institution \_\_\_\_\_ Position \_\_\_\_\_ Years: \_\_\_\_\_  
Institution \_\_\_\_\_ Position \_\_\_\_\_ Years: \_\_\_\_\_

**PLEASE INCLUDE AN UPDATED CURRICULUM VITAE OR RESUME WITH THIS APPLICATION**

Signature Required: *To the best of my knowledge, I certify that all information provided in this application is correct.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for your interest in MSU-CHM.