**Postgraduate Physician Assistant**

**Mental Health Residency**

VA Medical Center, Chillicothe Ohio

Dear Applicant:

Thank you for your interest in the Postgraduate PA Mental Health Residency program. Please provide requested information on the form in legible writing or type and complete all Final Instructions. Use plain paper if additional space is needed. Submit application to the address as listed on page 3. This document is considered *PRIVILEGED AND CONFIDENTIAL*. Release of information is protected under the Privacy Act.

Program Practice: Diversity will create an environment that enhances and improves service delivery, professional development, and the training experience as a whole. We value and affirm the diverse backgrounds, identities, and expressions of all people. We encourage those from diverse backgrounds to consider our training program.

|  |  |
| --- | --- |
| Name | Last First MI |
| Home  Address |  |
| Telephone | Home: Cell: |
| Date of Birth | MM/DD/Year |
| Email  Address(es) | (1)  (2) |
| Contact Person | Name and Address of contact person |
| Prior name(s) | Maiden name?  Name change? |
|  | Do you have any condition that may limit full participation in the program? If so, please describe. |
| Mandatory  Requirements | 1. Must have U.S. citizenship.  2. Must be registered with Selective Service (if male).  3. Must not have a felony conviction.  4. Must not have default on federal loan. |
| Education Debt Reduction  Program | If you are a new graduate, Veterans Health Administration uses the Education Debt Reduction Program (EDRP) as an incentive for recruitment and retention to full-time employees. **This does not apply to residency**. |

**Education history**

|  |  |  |  |
| --- | --- | --- | --- |
| Undergraduate Degree College/University | Address | Degree | From: To: |
| Name of PA Program | Address | Degree | From: To: |
| Doctorate or second degree (if applicable) | Address | Degree | From: To: |
| Type of Previous PA Residency (if applicable) | Address | From: To: | Did you complete the residency? Why or why not? |

**Clinical work history**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Facility | Address | From: To: | Why did you leave? |
| Name of Facility | Address | From: To: | Why did you leave? |

**Certification and license history**

|  |  |  |  |
| --- | --- | --- | --- |
| **1.** State & License No. | **1a** Type (circle one)  Full Limited Restricted | **1b** Date of First Issue | **1c**  Expiration Date |
| **2.** NCCPA No. | **2a** Date of First Issue | **2b** Expiration Date |  |
| **3.** DEA No. | **3a** Date of First Issue | **3b** Expiration Date | **3c**  Authorized Schedule (circle applicable)  2, 2N, 3, 3N, 4, 5 ALL |
| **4.** National Provider Bank Identification No. | **5.** Basic Life Support  Expiration Date |  |  |

**professional practice history**

|  |  |  |
| --- | --- | --- |
| Have you ever:  (**Yes** or **No** response) | - Been denied a license? Yes No  - Had a license restricted, revoked or suspended? **Yes No**  - Been reported to National Provider Data Bank? **Yes No**  - Had scope of practice limited?  **Yes No** | - Had hospital privileges restricted, suspended, or denied? **Yes No**  - Had disciplinary actions based on performance or professional conduct by any institution or training program? **Yes No**  - Attempted or completed a PA residency program in the past? **Yes No** |

*If* ***Yes*** *to any of the above, please provide explanation on plain paper and submit with the other materials.*

**Professional history**

Please list a few things accomplished professionally, both undergraduate and as a PA. This can include organizational membership, professional society, awards, publications, faculty appointments, etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Professional references**

Please have your reference complete the provided forms and submit as per instructions. For new or recent graduate, submit 2 references. For experienced PA, submit 3 references.

Name and title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Descriptive essay**

On a separate typed attachment no longer than 2 pages, describe how specializing in psychiatry will improve access to care for a population that may be marginalized. Include your experience with veterans (if any) and why you are willing to seek VA employment and take the Certificate of Added Qualifications in Psychiatry exam after completing the residency.

**Final Instructions**

1. Sealed or encrypted official college/university transcripts must be sent directly to Program Director at

the address below.

2. We will verify NCCPA certification on their website. If there is any question, you must contact NCCPA to

send a letter directly to Program Director for clarification.

3. Letter of reference forms must be completed and sent directly to Program Director at address below.

4. Must not have felony convictions.

5. Must be a U.S. citizen.

6. Must be registered with Selective Service (if male).

7. Must not have default on federal loan.

8. Applicants will be invited for an interview (phone or face to face) after all materials have been

submitted and determined to be a strong candidate.

9. Submission of Application signifies intent to attend and complete the Residency program.

10. Signature below certifies that to the best of your knowledge, the information you provided is accurate

and correct.

11. All information must be submitted by March 31.

12. Interviews by invitation only.

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

VA Medical Center

17273 State Route 104

Chillicothe, Ohio

Attn: Sherry S. Martin, PA-C #116A

Sherry.martin@va.gov