

New Mexico VA Health Care System Physician Assistant Residency in Mental Health

APPLICATION

Electronic applications are encouraged and should be emailed to Jason.Murray2@va.gov with cc to Laura.Cruz-Hinson@va.gov	
<p style="text-align: center;"><i>US Mail</i></p> <p>Jason Murray, MCMSc, PA-C Residency Director, Post-Graduate Physician Assistant Mental Health Residency NM VA Health Care System 1501 San Pedro Drive SE Albuquerque, NM 87108</p>	<p style="text-align: center;"><i>FedEx or other delivery service</i></p> <p>Jason Murray, MCMSc, PA-C Residency Director, Post-Graduate Physician Assistant Mental Health Residency NM VA Health Care System 1501 San Pedro Drive SE Albuquerque, NM 87108</p>
<p>Questions may be addressed to:</p> <p>Mr. Jason Murray, PA-C 505-265-1711 Ext. 7729 Jason.Murray2@va.gov</p> <p>Web: https://www.va.gov/new-mexico-health-care/work-with-us/internships-and-fellowships/physician-assistant-post-graduate-residency-in-mental-health-psychiatry/</p>	<p>Requirements:</p> <ul style="list-style-type: none"> Prior to beginning the program, applicants must have graduated from an ARC-PA accredited program Applicants must be US Citizens and, if applicable (male applicants born after 12/31/59) have registered for the draft by age 26 A personal essay is required, see detail below Documentation that vaccinations are up to date and that screening for active tuberculosis is complete prior to starting the residency Have a current, full, active, and unrestricted license to practice as a PA in a state or US territory

Begin: August 27, 2023

Application period: March 1, 2023- April 30, 2023
Rolling admissions are utilized so early application is encouraged

Admissions after September will be granted based on availability of positions. Those graduating too late to start in September are encouraged to apply

Name	Last	First	Middle	Present Address	
Telephone (Home)			Telephone (Cell)		Birth date MM/DD/YYYY
e-Mail					
Permanent Home Address				Name and address of someone always able to contact you	
Do you have any conditions which might impair your participation in this program? If so, please describe.					
Have you ever used any other name(s)?					

EDUCATION and EXPERIENCE (attach additional sheet(s) if necessary):

High School			From	To									
	Address												
College			From	To	Degree								
	Address												
PA Program			From	To	(Exp.) Grad. Date								
	Address												
	MS or PhD Included?		Research or Thesis Topic, if applicable										
Previous Residency (if applicable)	Program		From	To	Field								
	Address			City and State									
Graduate School (if applicable)	College		From	To	Degree(s)								
	Field(s)												
Practice or Other Clinical Experience	Location			From	To								
	Type												
	Location			From	To								
	Type												
Complete Licensing History (if applicable) Use additional sheet if necessary	State	TYPE <small>(Full, Standard, Limited, Restricted)</small>	STATUS	Dates									
	State		STATUS	Dates									
<p>Have you ever:</p> <table border="0"> <tr> <td><input type="checkbox"/> Been denied a license</td> <td><input type="checkbox"/> Had your Scope of Practice limited</td> </tr> <tr> <td><input type="checkbox"/> Had a license revoked or suspended</td> <td><input type="checkbox"/> Been denied hospital privileges</td> </tr> <tr> <td><input type="checkbox"/> Had other licensure issues</td> <td><input type="checkbox"/> Had hospital privileges limited or suspended</td> </tr> <tr> <td><input type="checkbox"/> Been reported to National Provider Database</td> <td><input type="checkbox"/> Been disciplined for academic performance or professional conduct by ANY institution or training program</td> </tr> </table> <p>If any of the above apply, please attach an additional sheet with explanation.</p>						<input type="checkbox"/> Been denied a license	<input type="checkbox"/> Had your Scope of Practice limited	<input type="checkbox"/> Had a license revoked or suspended	<input type="checkbox"/> Been denied hospital privileges	<input type="checkbox"/> Had other licensure issues	<input type="checkbox"/> Had hospital privileges limited or suspended	<input type="checkbox"/> Been reported to National Provider Database	<input type="checkbox"/> Been disciplined for academic performance or professional conduct by ANY institution or training program
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NCCPA Certification or Eligibility: _____ NPID# _____

Membership in Honorary or Professional Societies, prizes, awards, fellowships, etc. (attach extra sheet if necessary)

Publications and Faculty Appointments: If applicable, please list publications and/or faculty appointments on a separate sheet or include in CV.

PROFESSIONAL REFERENCES:

- Please request two (2) professional letters of evaluation to be E-mailed by the writer directly to Jason.Murray2@va.gov with cc to Laura.Cruz-Hinson@va.gov.
- It is encouraged that one letter be from the PA Program Director or supervising physician/PA.
- Please request that evaluators comment on academic and personal attributes including judgment, industry, interpersonal relations, capacity to assume responsibility and professional ethics.

Reference 1	Title
Reference 2	Title

PERSONAL STATEMENT

A personal essay with approximately 1000-1500 words is required describing the nature of your interest in and expectations of the program, professional goals, your strengths and weaknesses, and why you have chosen the NMVAHCS Residency Program.

CHECKLIST

The following required items are attached or completed:

- _____ Transcript requested from PA program
- _____ Transcript requested to be sent from any graduate-level programs attended
- _____ Documentation of NCCPA certification, if applicable
- _____ CV or resume
- _____ TWO letters of evaluation requested to be sent directly to the program
- _____ Personal statement
- _____ Proof of US Citizenship

Any documents submitted by E-mail should be sent to both Jason.Murray2@va.gov and to Laura.Cruz-Hinson@va.gov



Following the receipt of all documents, competitive applicants will be invited to participate in an interview.



VA policy is that all residents are to subject to random drug testing



I certify that to the best of my knowledge the above information is accurate and correct:

Signature: _____ Date: _____