Department of Medicine
PERSONAL INFORMATION FORM
For Clinical Officers of Instruction (OOI), CUMC NPs and PAs (OOA)

PART I TO BE COMPLETED BY EMPLOYEE

Full Legal Name: _____ **Gender:** Female ☐ Male ☐
Last Name **First Name** **Middle Name**

Social Security Number: _____ **Date of Birth:** MM/DD/YYYY

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed **Marital Status Date:** MM/DD/YYYY

Have you any prior affiliation with: ☐ **Columbia University** Department _____ ☐ **NYPH**

Ethnicity: ☐White ☐Black/African American ☐Hispanic/Latino ☐Asian ☐American Indian/Alaskan Native ☐Native Hawaiian/Pacific Islander

Citizenship Status: ☐ USA Citizen ☐ Permanent Resident - A#: _____ ☐ Visa Holder
Visa Type: _____ Expiration Date: MM/DD/YYYY Country of Citizenship: _____

USA Home Address: _____ **Home Phone:** _____
City, State, Zip: _____ **Mobile/Cell:** _____
Email: _____ **Fax:** _____
Emergency Contact Name: _____
Relation: _____ **Contact Phone:** _____

FOR CLINICAL FACULTY

NYS License: ☐License ☐ Limited-License ☐ Limited-Permit
License #: _____ **Profession:** _____ **Exp Date:** MM/DD/YYYY
DEA #: _____ **Exp Date:** MM/DD/YYYY **ECFMG:** ☐Indefinitely ☐ Limited-Exp Date: MM/DD/YYYY
Infection Control Completion Date: MM/DD/YYYY
Board Certificate Specialty: _____
Effective Date: MM/DD/YYYY **Expiration Date:** MM/DD/YYYY
Board Certificate Subspecialty: _____
Effective Date: MM/DD/YYYY **Expiration Date:** MM/DD/YYYY
Malpractice Insurance Carrier: _____
Policy #: _____ **Eff Date:** MM/DD/YYYY **Exp Date:** MM/DD/YYYY

PART II TO BE COMPLETED BY DIVISION ADMINISTRATION

Division: _____ **Unit:** _____
Status: ☐FT ☐PT **Eff Date:** MM/DD/YYYY **End Date:** MM/DD/YYYY
CU Title: _____ Non-Departmental Affiliation: _____
NYPH Title: _____ Sub-Specialty: _____

Admitting Privileges: NYPH ☐ Yes ☐ No
Additional Privileges Required: Moderate Sedation ☐ **CVC** ☐ **Laser** ☐ **Endovascular** ☐
Other Specify: _____
Position Supervisor / Collaborating Physician: _____
Work Address: _____
Work Phone: _____ **Work Fax:** _____

Compensation: ☐CU Salary ☐NYPH Salary ☐CU Stipend ☐None
Base: $_____ **AddComp1:** $_____ **AddComp2:** $_____