STANFORD UNIVERSITY
OFFICE OF POSTDOCTORAL AFFAIRS

POSTDOCTORAL SCHOLAR PATIENT CARE INFORMATION SHEET

(Required by the Graduate Medical Education Office for all MDs and all non-MDs with SHC patient contact except for Clinical Psychologists)

Name: _____ Social Security #: _____
(Last, First Middle Initial)

Department/Division: _____

Specialty: _____ Degree(s) Completed: ☐ MD ☐ PhD

Previous Institution: _____ Graduation date: _____
List the institution in which you received your MD and/or PhD degree (mm/dd/yyyy)

I confirm that I am credentialed to see patients at SHC for research and training purposes and also that the above referenced Postdoctoral Fellow will have:

☐ **No patient contact** during the fellowship at Stanford Hospital/Clinics **PI Initial:** _____
(Faculty Sponsor and Fellow must sign form. Do not complete any other portion of the Information Sheet.)

☐ **May have incidental patient contact** during his/her fellowship. **PI Initial:** _____
If patient contact only involves systematic investigation designed to develop or contribute to generalizable knowledge, check "No Patient Contact"and follow guidance at:
Medical Research: http://humansubjects.stanford.edu/research/medical/medical.html OR
Nonmedical Research: http://humansubjects.stanford.edu/research/nonmedical/nonmedical.html

☐ **Full patient care responsibilities** of a clinical fellow. **PI Initial:** _____

If full patient care, is this position an accredited fellowship: ☐ Yes, clinical year ☐ Yes, research year only ☐ No

If yes, please indicate the type of accreditation: ☐ ACGME ☐ ABMS ☐ Other _____

Will a request for billing privileges be submitted for the above referenced Postdoctoral Fellow? ☐ Yes ☐ No

If yes, attach the Agreement for Services Outside the Fellowship and include the "billing paragraph" in offer letter. Please note, Stanford does not allow ACGME fellows to bill for services. For fellows in "non-approved" programs, billing is restricted to services not in their areas of training.

California Medical License #: _____ Expiration Date: _____

Attach a copy of the Medical School diploma and a copy of the California Medical License showing the expiration date. For international medical school graduates, please also include a copy of the ECFMG certificate.

Postgraduate Year: ☐ I ☐ II ☐ III ☐ IV ☐ V ☐ Other _____

Previous Training (List Speciality & Location):

PGY I _____ Dates: _____

PGY II _____ Dates: _____

PGY III _____ Dates: _____

PGY IV _____ Dates: _____

PGY V _____ Dates: _____

Postdoctoral Fellow Signature: _____ Date: _____

Faculty Sponsor Name: _____ Title: _____

Faculty Sponsor Signature: _____ Date: _____

Submit form to the Graduate Medical Education Office at Stanford Hospital.
A copy should be uploaded with the appointment paperwork sent to the Office of Postdoctoral Affairs (OPA).
Maintain copy for department files.

Print Form