**Regional Programs Faculty Information Form**

The information requested on this form is needed for two purposes: a) the review of your faculty appointment by your Center Director, COM Department Chair and the Office of Faculty Affairs, and b) entry of educational and demographic data into FacFacts, the College of Medicine faculty database, upon which your adjunct faculty privileges depend. Please return the completed form to: Pam Pyland, UAMS West 612 South 12th Street, Fort Smith, AR 72901, or fax (479)785-0732, with a copy of your current Curriculum Vitae

**Please Print or Type:**

 Last Name First Name MI

List your annual contributions to UAMS West Regional Center – noting how they support the UAMS West Regional Center missions of teaching, clinical care, and/or research, and estimate of the time spent in each activity (Attach Separate page if needed):

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Credentials (i.e. M.D., Ph.D) Date of Birth (mm/dd/yy) Social-Security

Gender: \_\_\_\_Male \_\_\_\_Female

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Preferred Mailing Address City State Zip Code Country

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attach current Curriculum Vitae, OR provide information regarding highest level of education:**

**Medical School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Country\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Degree: \_\_\_\_\_\_\_\_\_\_MD \_\_\_\_\_\_\_\_\_\_DO \_\_\_\_\_\_\_\_\_\_\_\_\_Other**

**Primary Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year of Graduation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Residency Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Board Certified:  YES  NO**

**Original Certification Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Certification Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I understand that my faculty appointment requires a minimum of 20 hours of service annually to UAMS West Regional Center and UAMS College of Medicine. I agree to provide that service, if requested, and continue my appointment:  YES  NO**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please attach a CV and return in the self-addressed, stamped envelope.**

For Office Use Only:

Adjunct Faculty Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approvals: Center Director\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RP Vice-Chancellor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

College of Medicine Department Chair\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Faculty Affairs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Org#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_