THE UNIVERSITY OF ARIZONA.
College of Medicine

The Department of Medicine

AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the University of Arizona College of Medicine to access and verify my educational background and professional qualification I, **(PRINT NAME)**_____**,** authorize The University of Arizona College of Medicine to make inquiries concerning such information about me to my previous employer(s), current employer, educational institutions, state licensing boards, professional liability insurance carriers, American Medical Association, Federation of State Medical Boards, other professional organizations and/or persons, agencies, organizations or institutions listed by me as references and to any other appropriate sources to whom the University of Arizona College of Medicine may be referred by those contacted or deemed appropriate;

I understand that The University of Arizona recruiting practices require due diligence in making inquiries into my employment and educational background and this process may include contacting individuals whom I have suggested, as well as contacting other collateral sources whom I have not suggested.

I authorize release from liability all those who provide information to The University of Arizona College of Medicine in good faith and without malice in response to such inquiries and waive access to any written responses received by The University of Arizona College of Medicine to such inquiries.

I understand that any false statement or misrepresentation made by me, either in my application for employment or on any supplement thereto, may result in my dismissal should I be hired by The University of Arizona College of Medicine.

I authorize The University of Arizona College of Medicine to disclose to such persons, employers, institutions, boards or agencies identifying any other information about me to enable The University of Arizona College of Medicine to make such inquiries.

Signature _____Date _____

ATTESTATION STATEMENT & PHOTO AUTHORIZATION

I acknowledge that I have been informed where the sample Resident Agreement for a residency position in the Department of Medicine at the University of Arizona Health Sciences Center along with the institution's Policy on Eligibility and Selection of Residents may be found (medicine.arizona.edu/education). I also authorize The University of Arizona to use my ERAS picture within BUMC, the VA and TMC (all partner locations) if I match with this program.

Signature _____Date _____

Printed Name_____

CONFIDENTIALITY AGREEMENT

I understand that I will have partial information regarding who is interviewing in this program and I agree to keep this information confidential.

Signature _____Date _____

Applicant web address: https://heart.arizona.edu/education/cardiovascular-disease-fellowship-training-program/pre-interview-information