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|  | *Checklist for**Initial Faculty Appointment* |
|  | |

***Candidate for initial appointment*** ***Submission date***

***Department Section/specialty (Required - if applicable)***

**Step 1: Refer to Faculty Affairs website, Applying for Appointment, and read** ["Application Requirements for Faculty Appointment"](https://medicine.vtc.vt.edu/faculty-affairs/applying-for-appointment.html)

**Step 2: To be completed and submitted as one packet to the office of the department chair for the candidate’s specialty:**

   Letter of intent from the candidate seeking appointment ***(should include anticipated academic activities and express willingness to abide by the rules of the medical school and faculty)***

   Curriculum vitae

   Official transcript of terminal degree ***(official electronic transcripts should be sent to*** [***vtcsomfaculty@vt.edu***](mailto:vtcsomfaculty@vt.edu)***)***

   Faculty Information Form

   Faculty Conflict of Interest in Student Assessment and Promotion Management Form

   Elements Authorization form

   FERPA *(Family Educational Rights and Privacy Act of 1974)* Confidentiality Agreement for Faculty

   SCHEV *(State Council on Higher Education in Virginia)* Instructor Qualification Form

   Virginia Tech Non-Paid Affiliation Appointment form

Co-appointment *(select one of the following)*

   Not applicable

   Applicable in the department of

   If applicable, provide letter of recommendation from the Chair of the department in which co-appointment is being requested

**Step 3: To be completed by the office of the Department Chair:**

   Review initial appointment packet ensuring all items are included and accurate

   Include letter of recommendation from department chair ***(must include anticipated academic activities and clearly delineate rank and track)***

   If applicable, include letter of recommendation from chair of Departmental APRT Committee for initial appointments at rank of Associate Professor or Professor with tenure to title ***(must include anticipated academic activities and clearly delineate rank and track)***

   If applicable, include letter of recommendation from chair of Departmental APRT Committee for those who completed fellowship training during the preceding year at VTCSOM/Carilion Clinic (required by the university).

   Submit completed initial appointment packet to the Office of Faculty Affairs

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|  | *Faculty Information Form* |
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***Name: Contact information:***

Prefix Preferred mailing address

*(i.e., Dr., Mr., Ms.)*       *Address Line 1*

First Name       *Address Line 2*

Middle Name       City, State, Zip

Last Name      Preferred e-mail

Suffix *(i.e., Jr., Sr.)*       Alternate e-mail

If applicable,       Office Phone

alternative name under which you publish

*(e.g., an Anglicized name)* Cell Phone

Personal website

***Other:***

Carilion Clinic ID number *(if applicable)*

Virginia Tech ID number *(if applicable)*

Do you currently have a faculty appointment at another college at Virginia Tech? Yes  No

If so, are you tenured? Yes  No

*Self-identification*: Our accrediting bodies require we demonstrate efforts in recruiting a diverse faculty. Completion of the following section is voluntary; however, we hope you will choose to assist us in remaining compliant. The information provided is not used for employment purposes.

**Birth year**

**Birthplace**

**Gender** Male

Female

Other

**U.S. Citizen** Yes

No

**U.S. Armed** Yes

**Forces Veteran** No

**Race** *(check all that apply)*

American Indian or Alaskan Native

Asian

Black or African American

Hispanic, Latino or of Spanish origin

Native Hawaiian or other Pacific Islander

White

Other *(additional detail)*

*The Virginia Tech School of Medicine is an equal opportunity/affirmative action*

*institution and is certified by SCHEV to operate in Virginia.*

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|  | | *Faculty Conflict of Interest in Student Assessment and Promotion Management Form* |
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| **Related Policy:** Occasions may arise in which a faculty member has direct supervision over a student in matters of assessment and/or promotion and in which there may be a potential conflict of interest in this role. The conflict may arise as a consequence of any of a number of situations such as:   1. The student may be a relative through lineage, marriage, or other relationships; 2. The student may have a close personal relationship through settings such as places of worship, civic organizations, sports, recreational, or other social settings; 3. The student may be a patient in the practice of a clinical faculty member; 4. Or other relationships identified by the faculty member or student.   The nature of the conflict need not be disclosed. When such a conflict is recognized by the faculty member, it is the responsibility of the faculty member to notify the VTCSOM Office of Faculty Affairs, either through this document or directly. Should a conflict be identified by the student, the student should notify the VTCSOM Office of Student Affairs.  If a conflict of interest is identified by either party, the student schedule will be modified to avoid assessment of the student by the faculty member. Similarly, if a conflict of interest is identified, by either party, the faculty member will be asked to recuse him/herself in decisions regarding promotion of the student.  **Related Accreditation Standard:** LCME 12.5, Faculty Involvement in Student Assessment | | |
| Name: | | |
| **I do not have any conflicts at this time.** | | |
| I have conflicts with the following student/s: | | |
|  | | |
| **Faculty member name**  *(printed)*: |  | |
| **Signature**  *(typed or handwritten)***:** |  | |
| **Date:** |  | |
| *Contact the Office of Faculty Affairs at any time*  *during the academic year in which a conflict of interest arises.* | | |

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|  | | *Elements Authorization Form* |
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| ***Select one of the following two options:*** | | |
| **In addition to myself, I also authorize the individual(s) listed below access to my Elements account:**  Insert name(s) of who will assist with my account | | |
| **I prefer to solely manage my own Elements account.** | | |
| **Your Signature:**  *(typed or handwritten)* |  | |
| **Your Printed Name:** |  | |
| **Date:** |  | |
| *Email* [*vtcsomfaculty@vt.edu*](mailto:vtcsomfaculty@vt.edu) *whenever a change in authorization occurs.* | | |



Office of Enrollment Management

2 Riverside Circle, Suite M140

Roanoke, VA 24016

Telephone: (540) 526-2512

Fax: (540) 342-1823

[hvreynolds@vt.edu](mailto:hvreynolds@vt.edu)

2 Riverside Circle, Suite M140

Roanoke, VA 24016

Telephone: (540) 526-2512

Fax: (540)342-1823

[hvreynolds@vt.edu](mailto:hvreynolds@vt.edu)

***Office of Enrollment Management/Registrar***

**FERPA Confidentiality Agreement for Faculty**

I understand that by virtue of my affiliation with Virginia Tech Carilion School of Medicine, so long as I have a legitimate educational interest in accessing those records, I may have access to student records that contain individually identifiable information, the disclosure of which is specifically limited by the *Family Educational Rights and Privacy Act of 1974* (FERPA). Furthermore, civil penalties may be imposed under Virginia’s state privacy laws.

I understand that all information contained in Banner, Blackboard, B-Line, Canvas, Elements, one45, and any other electronic databases that house educational records are regulated by school policy and procedures. Any unauthorized use of these systems could result in the loss of access to student records and possible disciplinary action with Virginia Tech Carilion School of Medicine.

I further acknowledge that such willful or unauthorized disclosure also violates Virginia Tech Carilion School of Medicine policy and could constitute termination of my employment.

I understand that when writing letters of recommendation on behalf of students (if applicable) who are submitting VSAS/ERAS applications, the disclosure is subject to the requirements of FERPA. Section §99.30, and VTCSOM require the writer to obtain a signed release form from the student which (1) specifies the records/data that may be disclosed, (2) state the purpose of the disclosure, and (3) identifies the party/parties to whom the disclosure may be made. A recommendation letter request form can be obtained in the Registrar’s Office for student convenience.

By signing this form, I affirm that I have reviewed and understand all information regarding FERPA provided to me by Virginia Tech Carilion School of Medicine.

Signature Date

Printed Name

Questions regarding this agreement or FERPA should be directed to the Registrar at 540.526.2199 or [tljones@vt.edu](mailto:tljones@vt.edu).

**Family Educational Rights and Privacy Act (FERPA)**

The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.

FERPA gives **eligible students** rights with respect to their education records.

**Eligible students** have the right to inspect and review the student education records maintained by the school. Schools are not required to provide copies of records unless, for reasons such as great distance, it is impossible for eligible students to review the records. Schools may charge a fee for copies.

**Eligible students** have the right to request that a school correct records which they believe to be inaccurate or misleading. If the school decides not to amend the record, the eligible student then has the right to a formal hearing. After the hearing, if the school still decides not to amend the record, the eligible student has the right to place a statement with the record setting forth his or her view about the contested information.

Generally, schools must have written permission from the **eligible student** in order to release any information from a student's education record. However, FERPA allows schools to disclose those records, without consent, to the following parties or under the following conditions (34 CFR § 99.31):

* + School officials with legitimate educational interest;
  + Other schools to which a student is transferring;
  + Specified officials for audit or evaluation purposes;
  + Appropriate parties in connection with financial aid to a student;
  + Organizations conducting certain studies for or on behalf of the school;
  + Accrediting organizations;
  + To comply with a judicial order or lawfully issued subpoena;
  + Appropriate officials in cases of health and safety emergencies

Schools may disclose, without consent, "directory" information such as a student's name, address, telephone number, date and place of birth, honors and awards, and dates of attendance. However, schools must tell eligible students about directory information and allow eligible students a reasonable amount of time to request that the school not disclose directory information about them. Schools must notify eligible students annually of their rights under FERPA. The actual means of notification (special letter, inclusion in a student handbook, or newspaper article) is left to the discretion of each school.

For additional information, you may contact the Registrar at the following address:

VTCSOM

Office of the Registrar

2 Riverside Circle, Suite M140  
Roanoke, VA 24016

(540) 526-2512

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| --- | --- | --- |
| SCHEV  James Monroe Building  101 North Fourteenth Street  Richmond, Virginia 23219 | **State Council of Higher Education for Virginia** | Phone: (804) 225-2600  Fax: (804) 225-2604  TDD: (804) 371-8017  Web: www.schev.edu |

**Instructor Qualification**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Personnel Data** | | | | | | | | | | | | | | |
| Full Name: | |  | | | | |  | | | |  | Date: | |  |
| *Last* | | | | | | | *First* | | | | *M.I.* | | | |
| Phone: | | **(****)** | | | | | | | | | Work Cell #: | | | **(****)** |
| Work Fax: | **(****)** | | | | | | | E-mail Address: |  | | | | | |
| Date of Initial Employment: | | |  | | | Full Time: | |  | | Part Time: | | |  | |
| **Name of School (Employer):** | | | | | **Virginia Tech Carilion School of Medicine** | | | | | | | | | |
| **Courses that will be taught:** | | | | **Problem-based learning curriculum: combination of lectures, facilitation of small team group discussions and/or clinical skills throughout the four years** | | | | | | | | | | |
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| **Education** | | | | | | |
| **Institution Attended** (Name plus city & state of location) | **Graduated?**  Yes No | | **Certificate, Diploma or Degree Earned** | **Major Area of Study** | **Dates Attended**  **From To**  (Mo./Yr.) (Mo./Yr.) | |
|  |  |  | Please see attached CV |  |  |  |
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| **Teaching and or Work Experience** | | | | | | | | | |
| Employer |  | | | | | | Job Title: | |  |
| Address: |  | | | | | | | | |
| Subject Taught : |  | | | | | | | | |
| Job Duties or Responsibilities: | | Please see attached CV | | | | | | | |
| Length of Work Experience | | |  | From: |  | To: | |  | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Employer |  | | | | | | Job Title: | |  |
| Address: |  | | | | | | | | |
| Subject Taught: |  | | | | | | | | |
| Job Duties or Responsibilities: | |  | | | | | | | |
| Length of Work Experience: | | |  | From: |  | To: | |  | |
|  | | | | | | | | | |
| **Attach separate sheet with additional work experience** | | | | | | | | | |
|  | | | | | | | | | |

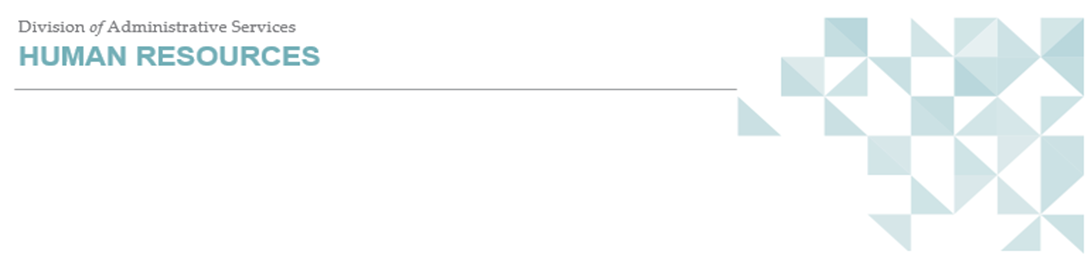
|  |
| --- |
| **Other Relevant Experience** |
| Please see attached CV |
|  |
| **Certifications/Licenses:** (Attach a copy of faculty member’ credentials) |

|  |  |  |
| --- | --- | --- |
| Occupational Licenses, Certifications or Registrations Held  Please see attached CV | State Issued | Expiration Date |
|  |  |  |
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| **Verification of Qualification** (SCHEV regulations require faculty members to have at least one of the qualifications listed below. Indicate all the qualification that apply and attach the supporting documentation.) |

|  |  |
| --- | --- |
| **Faculty teaching A.A.S or A.O.S level:** | |
|  | Associate degree from an accredited college/university in discipline being taught if teaching occupational/technical courses (attach copies of official transcript) |
|  | Baccalaureate degree from an accredited college/university plus at least 18 graduate credits in discipline being taught if teaching general education courses ( attach copies of official transcript) |
|  | Qualifies for faculty appointment by virtue of scholarly or professional achievement (attach letter from school director documenting on what basis this determination was made **plus** any documents that support the appointment e.g. resume, copies of certificates held, licenses) |
| **Faculty teaching on college-transfer program at the Associate level:** | |
|  | Baccalaureate degree from an accredited college/university from an accredited college/university in discipline being taught ( attach copies of official transcript) |
|  | Baccalaureate degree from an accredited college/university plus at least 18 graduate credits in discipline being taught if teaching general education courses or in programs in the liberal arts and science ( attach copies of official transcript)  Virginia Tech Carilion School of Medicine faculty will teach at the doctoral level (M.D.) |
|  | Qualifies for faculty appointment by virtue of scholarly or professional achievement (attach letter from school director documenting on what basis this determination was made **plus** any documents that support the appointment e.g. resume, copies of certificates held, licenses) |
| **Faculty teaching on Baccalaureate level:** | |
|  | Master’s degree from an accredited college/university in discipline being taught ( attach copies of official transcript) |
|  | Master’s degree from an accredited college/university plus at least 18 graduate credits in discipline being taught if baccalaureate degree is in a different discipline ( attach copies of official transcript) |
|  | Qualifies for faculty appointment by virtue of scholarly or professional achievement (attach letter from school director documenting on what basis this determination was made **plus** any documents that support the appointment e.g. resume or vitae, list of scholarly publications, etc) |
| **Faculty teaching on Master’s level:** | |
|  | Doctoral or other terminal degree in discipline being taught from an accredited college/university ( attach copies of official transcript) |
|  | Qualifies for faculty appointment by virtue of scholarly or professional achievement (attach letter from school director documenting on what basis this determination was made **plus** any documents that support the appointment e.g. resume or vitae, list of scholarly publications, etc) |
| **Faculty teaching technical courses for career-technical programs not leading to a degree and not offered as degree credit:** | |
|  | Associate degree from an accredited college/university related to the area of instruction ( attach copies of official transcript) |
|  | Two years of technical/occupational experience in the area of teaching responsibility (attach resume) |

|  |  |  |  |
| --- | --- | --- | --- |
| **Disclaimer and Signature** | | | |
|  | | | |
| I certify that the foregoing statements are true and complete to the best of my knowledge. I understand that false or misleading information may result in my release.  Signature of Applicant:  Date: | | | |
| As an authorized school official, I have carefully reviewed and verified the qualifications of the employee and his/her statements contained on this application. To the best of my knowledge and belief, he/she is qualified for the position as required by the rules for the State Council of Higher Education for Virginia. I understand false and misleading information may result in the suspension and/or revocation of the school’s Certificate to Operate, pursuant to § 23.1-221 of the Code of Virginia. | | | |
| Signature: |  | Date: |  |

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**NON-PAID AFFILIATION APPOINTMENT**

Upon completion and departmental approval, this form should be forwarded to the department representative who is responsible for entering the affiliation in Banner. The departmental representative should retain this form in the departmental files.

**You may complete this form using the paper version below or online version by using the link** [**here**](https://forms.office.com/Pages/ResponsePage.aspx?id=hGiVYK0Q-kCGPU8yweOjep00e0Th_S9Cm6HKTAYZ01JUQTJUMENKMU44SkpGSDhVWjEwN0UzTEw0Wi4u)**.**

Name:       Virginia Tech Assigned number:

(Only applicable if you have had a VT ID# previously)

Mailing address:       Carilion Clinic Badge number:

City:       (Only applicable to those who work for Carilion Clinic)

State/ZIP code:

   I do not wish to have my home address listed in the campus directory.

Home phone number: (   )     -

   I do not wish to have my home phone number listed in the campus directory.

Date of birth:

Country of citizenship:

If Non-US citizen: (check one)    Non-resident alien    Resident alien    Non-citizen national

**Gender:**    Male    Female

**Ethnicity: Hispanic or Latino?**    Yes    No

A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

**Race:** Check all that apply

|  |  |
| --- | --- |
| **American Indian or Alaskan Native**  A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. | **Asian**  A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent; for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. |
| **Black**  A person having origins in any of the black racial groups of Africa. | **Native Hawaiian or Other Pacific Islander**  A person having origins in any of the original peoples of  Hawaii, Guam, Samoa, or other Pacific Islands. |
| **White**  A person having origins in any of the original peoples of  Europe, the Middle East, or North Africa. | **Other**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

***Bottom portion to be completed by Virginia Tech***

**Position Information**

Indicate position type:   **New**    **Extension**

Position title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Extension date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approve the appointment and information provided above:**

Department head/designee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Virginia Tech assigned number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Virginia Tech Non-Paid Affiliation Appointment form