KernMedical

Date

RE: ACCEPTANCE LETTER

Dear Doctor,

On behalf of the Kern Medical Residency Program, we are happy to offer you a PGY-1 Resident position from be _____ – _____ .

Acceptance into this Residency Program is contingent upon your meeting all Kern Medical, Kern County Hospital Authority, ECFMG (when applicable), and State of California Medical Board Postgraduate Training License requirements. The requirements include but are not limited to pre-employment physical, mandatory drug and alcohol screening tests, completion of a background screening questionnaire to include but not limited to national wants and warrants, Office of Inspector General (OIG) exclusions, criminal search, social security name match, and sex offender registry. This offer of employment will be withdrawn if you are unable to present satisfactory evidence of compliance with all requirements prior to the initiation of your training.

As a reminder, Kern Medical has a zero-tolerance policy for substance abuse. Failure to pass the mandatory pre-employment drug and alcohol screening tests will result in you becoming ineligible for the Residency and Fellowship Programs at Kern Medical and will immediately disqualify you from participating in our Residency and Fellowship Programs. In accordance with our obligations under the National Residency Match Program, any individual who becomes ineligible will be notified of the finding, and a waiver request will be submitted to the NRMP for your match position.

Please confirm your acceptance of this position by signing the following signature page and returning the scanned document to your Residency Coordinator.

Thank you.

I hereby accept a position as a PGY-1 in the Residency Program at Kern Medical in Bakersfield, California.

The training dates at this PGY-1 level will be _____ through _____ . I understand this offer is contingent upon my completing all Kern Medical pre-employment and the State of California Medical Board Post Graduate Training and licensing requirements by June _____ .

_____   _____
Doctor Signature   Date

_____   _____
Director of Medical Education   Program Chair
Designated Institutional Official

_____   _____
Program Director   Residency Coordinator