**UNIVERSITY OF PITTSBURGH PHYSICIANS / UNIVERSITY OF PITTSBURGH SoM**

## Offer Letter Cover Form

# REQUESTOR INFORMATION:

# Requestor/Contact Name: Phone Number:

# Email Address: Fax Number:

# Department/Division:

**NOTE:** This form is for informational purposes only and **WILL NOT** be used for implementing payroll setup/changes. Please submit appropriate Appointment Forms and/or signed documents.

**CANDIDATE INFORMATION:**

# Candidate’s Name: Medical Specialty:

Candidate’s Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Current Position (rank): Current Employer(s):

# Proposed UPP/SoM Position (rank): Proposed Length of Appointment:

Proposed Start Date: [ ]  Non-Tenure [ ]  Tenure Stream [ ]  Tenure

Reason for Hire:

[ ]  New

[ ]  Replacement For whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Termination Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Acquisition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Other (explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**UPP Position Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is Position Budgeted? **[ ]**  Yes **[ ]**  No

**Pitt Position Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is Position Budgeted? **[ ]**  Yes **[ ]**  No

UPMC Cost Center \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ University Account Number? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Proposed Employment Status: **[ ]** Full-Time **[ ]** Part-Time **[ ]**  Casual **[ ]**  Flex Full Time *(only if PT SoM)*

If candidate will be employed casually, will they be employed at the University of Pittsburgh as well? Yes No

 If yes, how much will their salary be over at the University?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Proposed (Actual) Total Work Hours:

# Proposed Clinical Effort % (should match proposed Exhibit):

**Is this candidate a US Citizen or Permanent Resident?  \_\_ yes   \_\_\_\_ no   If no, what type of work authorization will they have? (i.e., H-1B, O-1, EAD . . . )** ­­­­­­­­­­­­­­­­­­­­­­­­­

Will this candidate have privileges at a UPMC facility? [ ]  Yes [ ]  No

If yes, which facility(ies) will you be requesting privileges for? (please check the selected locations)

**[ ]** Childrens Hospital of Pittsburgh of UPMC **[ ]** UPMC Bedford

**[ ]** Childrens Hospital of Pittsburgh of UPMC, North **[ ]** UPMC St. Margaret

**[ ]** Childrens Hospital of Pittsburgh of UPMC, South **[ ]** UPMC St. Margaret Harmar Outpatient Center

**[ ]** Magee Womens Hospital of UPMC **[ ]** UPMC Horizon

**[ ]** UPMC Mercy **[ ]** UPMC McKeesport

**[ ]** UPMC Mercy, South Side Surgery Center **[ ]** UPMC Northwest

**[ ]** Monroeville Outpatient Center **[ ]** UPMC Passavant and Passavant Cranberry

**[ ]** UPMC Presbyterian **[ ]** UPMC Shadyside

**[ ]** UPMC Presbyterian South Surgery Center **[ ]** UPMC Hamot

**[ ]** UPMC East

Will this candidate be employed within multiple UPMC entities concurrently (e.g. GME and UPP)? [ ]  Yes [ ]  No**UNIVERSITY OF PITTSBURGH PHYSICIANS / UNIVERSITY OF PITTSBURGH SoM**

## Offer Letter Cover Form - Page 2

**CANDIDATE’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAY CATEGORY** [ ]  UPP Only [ ]  A [ ]  C\* [ ]  Z\*\* - Non-ACGME Fellow [ ]  T (T-32)

***Pay Category C Candidates:***

* *You must list all active grant support which will be transferred to the University of Pittsburgh. Include base salary support for the proposed faculty member.*
* *You must list all pending grant support and outline a timeframe for anticipated grant support (including percent of base salary to be funded) for all years of the initial appointment (i.e. Year 1, Year 2, Year 3, etc.)*

***Pay Category Z Canidates (Non-ACGME Fellows):***

* *All Non-ACGME Fellows* ***must receive a letter or certification*** *for the additional training they will receive during their fellowship in order to be classified as a Non-ACGME and receive the 50% discount from MCare.*
* *You must answer “Yes” to at least one of the following questions: (circle one)*
	+ *Is there a formal match with a specialty society accredited Program? Yes No*
	+ *Are Board Certifications offered without a corresponding ACGME program? Yes No*
	+ *Are the formal educational requirements or competency training that must be*

*reported at the completion of the program? Yes No*

* + *Is there a formal or informal evaluation process of the physician? Yes No*

**\*\*\*Pre-Offer Malpractice Screening Requirement\*\*\***

**Check box to the right certifying that the Pre-Offer Malpractice History Review was completed for this candidate****[ ]**

**PLEASE ATTACH COPY OF NPDB APPROVAL E-MAIL**

**Was a claims history reported/identified during the Pre-Offer Malpractice History Review process?** [ ] Yes [ ] No

*\*If yes, you must submit a copy of the completed screening form with the offer letter packet.* *[ ]* N/A

**Check box if a review wasn’t required due to candidate already covered by Tri-Century Insurance** **[ ]**

REFERENCE CHECKS:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Institution:­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:­\_\_\_\_\_\_\_\_\_ Completed By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Institution:­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:­\_\_\_\_\_\_\_\_\_ Completed By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Institution:­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:­\_\_\_\_\_\_\_\_\_ Completed By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PROPOSED COMPENSATION: Dep’t. Admin. Approval:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SoM Base: Reviewed by Physician Services:

UPP Base: *Finance Approval:*

VAMC Base: *Contract Administrator:*

Total Base:

SoM Incentive \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SoM Administrative Supplement:

UPP Incentive: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UPP Supplement: Sent to Dean’s Office for Approval: *[ ]* N/A

UPP Administrative Supplement: Date Submitted: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Rev 01/12/17**

Total Proposed Compensation: Date Returned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| PLEASE DELIVER ALL NON-UPP OFFER LETTERS TO:UNIVERSITY OF PITTSBURGHDIANE HUCHBER441 SCAIFE HALLPHONE: 648-3218 FAX: 648-3222 | PLEASE DELIVER ALL UPP OFFER LETTERS TO:PHYSICIAN SERVICESCONTRACT ADMINSTRATION9035 FORBES TOWERDONA SAVKA - PHONE: 412-802-8257 FAX: 647-2039 |