



UNIVERSITY HEALTH SYSTEM
GRADUATE MEDICAL EDUCATION APPLICATION

PROGRAM INFORMATION

I am applying for a position as a Resident in the Department of:		beginning in:	
			(Mo) (Year)
Subspecialty Interest? <input type="checkbox"/> Yes or <input type="checkbox"/> No	If YES which specialty?		

PERSONAL INFORMATION

Name:			
Last	First	Middle Initial	
Home Address	City and State	Zip Code	
Office Address	City and State	Zip Code	

Office Telephone	()	Home Telephone	()
Date of Birth		Place of Birth	
Marital Status		Name of Spouse	

Do you speak a foreign language?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
If "YES" what language do you speak?	
If alien, Date of entry:	
Type of Visa: (Please provide copy)	
Visa Number:	

Military Status		Date of Service	
Branch of Service		Type of Discharge	

EDUCATIONAL INFORMATION

Pre-professional Education

Name of School	
Address:	
Date /Degree Conferred:	

Name of School	
Address:	
Date /Degree Conferred:	



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DO YOU POSSESS YOUR ORIGINAL MEDICAL/DENTAL DIPLOMA?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
CERTIFICATION BY NATIONAL BOARD OF MEDICAL/DENTAL EXAMINERS?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
CERTIFICATION BY AMERICAN SPECIALTY BOARD?	<input type="checkbox"/> Yes or <input type="checkbox"/> No

Professional Education

Name of School	
Address:	
Date /Degree Conferred:	

Name of School	
Address:	
Date /Degree Conferred:	

Internship

Institution	
Address:	
Type of Internship:	
To: From:	

Institution	
Address:	
Type of Internship:	
To: From:	

Residency

Institution	
Address:	
Type of Residency:	
To: From:	

Institution	
Address:	
Type of Residency:	
To: From:	

Fellowship

Institution	
Address:	
Type of Fellowship:	
To: From:	

Institution	
Address:	
Type of Fellowship:	
To: From:	



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CHRONOLOGICAL INFORMATION

Provide a chronological statement of your life/work experiences since high school:

Month/Year	Describe Experiences	(Location city/state)	Contact Telephone #
_____ to _____			
_____ to _____			
_____ to _____			
_____ to _____			
_____ to _____			

MEMBERSHIP IN PROFESSIONAL SOCIETIES

Society Name	From	To

SCHOLARSHIPS, PRIZES OR AWARDS RECEIVED

SCHOLARSHIP, PRIZE OR AWARD NAME

CLINICAL REFERENCES: Clinical References are Chairman, Program Directors, Medical School Professors, Chief Resident, etc.

CLINICAL REFERENCES <small>Please utilize the attached University Health System forms (3) to complete References</small>			
Name		Name	
Address		Address	
Dates		Dates	
Name		Name	
Address		Address	
Dates		Dates	



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LICENSURE INFORMATION

ALL STATE AND FEDERAL LICENSES

State Licensure:		Date Issued:		Number:	
State Licensure:		Date Issued:		Number:	
State Licensure:		Date Issued:		Number:	

Are there any actions or proceedings which have involved the suspension or revocation of your license or limited permit in any State or jurisdiction?	If "YES", please describe on a separate page. <input type="checkbox"/> Yes or <input type="checkbox"/> No
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TESTING INFORMATION

Test	Date	Date	Information	Number of attempts
<input type="checkbox"/> USMLE, Part I	Date:		Grade Average/Percentile:	
<input type="checkbox"/> USMLE, Part II	Date:		Grade Average/Percentile	
<input type="checkbox"/> USMLE, Part III	Date:		Grade Average/Percentile	
<input type="checkbox"/> NBME, Part I	Date:		Pass/Fail:	
<input type="checkbox"/> NBME, Part II	Date:		Pass/Fail:	
<input type="checkbox"/> NBME, Part III	Date:		Pass/Fail:	
<input type="checkbox"/> FLEX, Component I	Date:		Score:	
<input type="checkbox"/> FLEX, Component II	Date:		Score:	
<input type="checkbox"/> ECFMG English Test	Date:		Expiration Date:	
<input type="checkbox"/> FMGEMS, Part I	Date:		Percent	
<input type="checkbox"/> FMGEMS, Part II	Date:		Percent:	
<input type="checkbox"/> ECFMG	Applicant#:		(Please attach copy of ECFMG Certificate)	

GENERAL INFORMATION

1.	Have you ever elected to leave any program of education and/or training prior to completion?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
2.	Have you ever been asked or directed to leave any program of education and/or training prior to completion?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
3.	Are there any actions or proceedings which have involved the imposition of a sanction or dismissal from any program of education and/or training date?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
4.	Have you ever pleaded guilty or been convicted of a crime or offense other than a minor traffic violation?	<input type="checkbox"/> Yes or <input type="checkbox"/> No

If you answered "YES" to any of the above questions, please provide details on a separate page.



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PERSONAL STATEMENT

Please describe your professional interests, achievements, and plans for the future. If you wish, you may also attach your own personal signed statement.

REMARKS

CONSENT FOR RELEASE OF INFORMATION

I authorize the University Health System and its representatives to make inquiries of medical school registrars, members of the medical staffs or other institutions with which I have been associated, or others, regarding graduation, specific training, experience and current competence.

In connection with the evaluation of my application for the Graduate Training Program, I hereby release from liability all representatives of University Health System, its Medical-Dental Staff, and any other individuals, entities and organizations who may provide information to the University Health System and its Medical-Dental Staff, for their acts performed in good faith and without malice.

I understand and agree that I have the responsibility to produce adequate information for the proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. I hereby consent to the release of the above-mentioned information to the officials of the University Health System.

Date

Signature

Printed Name