

## Application for Appointment in a Residency or Fellowship Training Program

Program In: \_\_\_\_\_ PGY Level: \_\_\_\_\_

Training to Begin: \_\_\_\_\_ Number of Years of Training Sought: \_\_\_\_\_

### Personal Information

Full Name: \_\_\_\_\_  
*Last First M.I.*

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Present Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*  
\_\_\_\_\_  
*City State ZIP Code*

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

### Education

List all schools and inclusive dates attended.

	School Name and Location	Major Field	Degree	Dates
Undergraduate:				
Graduate:				
Medical School:				

### Residency Training

Hospital Name and Location	Program	Dates

Please indicate other professional activities (practice, research, military, training, etc.) since graduation from medical school:

Activity	Location	Dates

**Current Licensure & Examinations**

State \_\_\_\_\_ Type (Unrestricted or Training) \_\_\_\_\_ Number \_\_\_\_\_ Date Issued \_\_\_\_\_ Date Expired \_\_\_\_\_

United States Medical Licensing Examination (USMLE) \_\_\_\_\_ OR COMLEX \_\_\_\_\_ (for D.O.)

	Date Taken	Score		Date Taken	Score
Step 1	_____	_____	Level 1	_____	_____
Step 2 CK	_____	_____	Level 2 CE	_____	_____
Step 2 CS	_____	_____	Level 2 PE	_____	_____
Step 3	_____	_____	Level 3	_____	_____

**American Specialty Boards**

Eligible in: \_\_\_\_\_  
Certified in: \_\_\_\_\_  
Date: \_\_\_\_\_

**ECFMG & VISA Status**

**ECFMG STATUS**

ECFMG Number: \_\_\_\_\_  
Date Issued: \_\_\_\_\_

**VISA STATUS – If you are not a citizen of the U.S., please provide the following information:**

Current Non-Immigrant (Temporary) Visa Type: \_\_\_\_\_ Sponsor: \_\_\_\_\_

Or

Current Immigrant (Permanent) Status: \_\_\_\_\_

Requested Visa or Immigration Status at the time of Appointment: \_\_\_\_\_

**National Match Program/Interview**

Have you signed an agreement with the National Resident Matching Program? \_\_\_\_\_ Number: \_\_\_\_\_

When are you available for an interview? \_\_\_\_\_

**Additional Information**

ADDITIONAL INFORMATION: (Please list honors, research projects, special interests, publications, teaching appointments and relevant work experiences; or attach a copy of your curriculum vitae or resume and a personal statement.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TRAINING PLANS (What type and how many years of training do you anticipate):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CAREER GOALS (What are your career plans and preferences):

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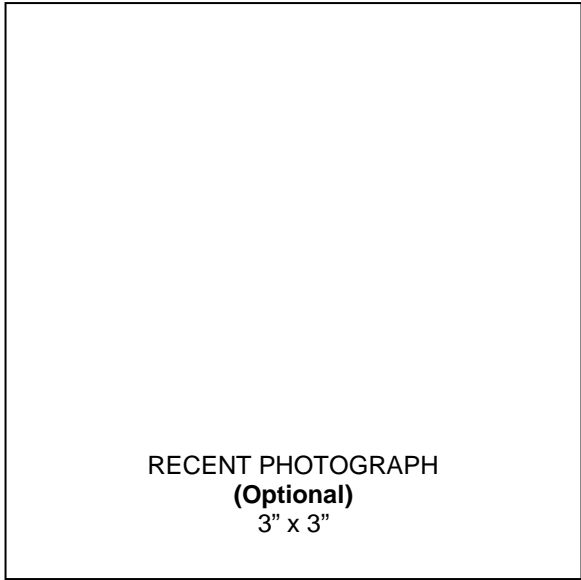
**References**

List three faculty members of your medical school or attending physicians who are familiar with your clinical performance and request that letters of reference be sent directly to the UMMC Program Director.

	First – Last Name & Title	Address
1.	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>

Date of Application: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_



Please return application to the Director of the UMMS Program to which you are applying, and request the Dean of your medical school to submit to the UMMS Program Director appropriate medical school credentials and Dean's Letters.

PLEASE NOTE: The University of Massachusetts Medical Center is an Affirmative Action/Equal Opportunity Employer and is committed to increasing minority representation among its Residents and Fellows. If you wish to do so, please list your minority status: \_\_\_\_\_