Jefferson Health

Application for Graduate Training

PLEASE MOUNT PHOTOGRAPH HERE OR ELECTRONICALLY ATTACH PHOTO

Instructions:

1. Type or print legibly
2. Attached required documents
   - current curriculum vitae (include all activities since medical school graduation with month/year format)
   - copy of medical school transcript and/or Dean's Letter
   - copy USMLE or COMLEX scores
   - copy of ECFMG Certificate, if applicable
3. Request three letters of recommendation be sent to the program to which you are applying as follows:
   - Dean's Letter counts as one of the three letters of recommendation
   - House Staff currently in a training program, one of the letters must be from your current Program Director
   - If you have been in practice, you must provide a letter of recommendation from the Chief of Staff of the hospital where you are currently practicing or from the county medical or osteopathic society.

Residency or Fellowship Request

Department	Dates of Proposed Training to

Personal Information

Name (Last, First, Middle)	MD/DO/DMD/DDS	Gender
Mailing Address (Street)	Telephone Number	Cell Number
(City, State, Zip Code)	E-Mail Address	
Permanent Address (Street)	Telephone Number	
(City, State, Zip Code)		

Social Security Number	Age	Date of Birth (Month/Day/Year)	Place of Birth
U.S. Citizen ☐ Yes ☐ No	If not, citizen of what country?		

Type of Visa on which you have entered/ will enter the United States (Education, Immigrant, Other)

Educational Commission for Foreign Medical Graduates (ECFMG) Number (Attach copy of certificate)

Can you perform the essential functions of your residency/fellowship position with or without reasonable accommodation? ☐ Yes ☐ No

If No, Please Explain

Marital Status	Name of Spouse	Address
If not married, name of nearest next of kin		Address

Military Status (Dates of Service)

Undergraduate Education

(Name, City, State, Country)	Date of Attendance to	Degree

Medical School Education

(Name, City, State, Country)	Date of Attendance to	Degree

Current Post Graduate Hospital Training

First Post Graduate year or Internship Hospital (Name, Address)

Specialty	Dates of training to
Board Credit Year	Program Director

Residency Hospital (Name, Address)

Type of Residency	Dates of training to
Board Credit Years	Program Director

Additional Hospital Training (Name, Address)

Type of Training	Dates of training to
Board Credit Years	Program Director or Chief

Please indicate the exams you have taken: (Please attach copies of exam results)

☐ USMLE, Step 1	☐ COMLEX, Step 1	☐ NBME, Part 1	☐ FLEX I	☐ NBDE, Part 1
☐ USMLE, Step 2 CK	☐ COMLEX, Step 2 CK	☐ NBME, Part II	☐ FLEX II	☐ NBDE, Part 2
☐ USMLE, Step 2 CS	☐ COMLEX, Step 2 CS	☐ NBME, Part III		
☐ USMLE, Step 3	☐ COMLEX, Step 3			

Pennsylvania Licensure Information (attach copy of license)

Are you currently licensed in Pennsylvania? ☐Yes ☐No If yes, provide License Number _____

If no, do you have a license pending? ☐ Yes ☐ No

If yes, what type? ☐MT ☐MD ☐OT ☐OS ☐DS

Do you belong to a county medical society? ☐ Yes ☐ No	If yes, which one?

Membership in Honorary/Professional Societies

Professional References (List below the names and addresses of three professional references, at least one of whom is a medical college faculty reference.

Name 1.	Title	Years of Acquaintance	Telephone
Address (Street, City, State, Zip/Postal Code)		Email	
Name 2.	Title	Years of Acquaintance	Telephone
Address (Street, City, State, Zip/Postal Code)		Email	
Name 3.	Title	Years of Acquaintance	Telephone
Address (Street, City, State, Zip/Postal Code)		Email	

In signing this application the physician submitting hereby certifies that the information given is true. Appointments are contingent upon the successful completion of the applicant's current year of graduate medical training, the requirements of the Pennsylvania State Board of Medicine and the Thomas Jefferson University Hospital Graduate Medical Education Committee.

Signature of Applicant _____ Date _____