

# Application for Graduate Training

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PHOTOGRAPH

For Residency (Department)

For Fellowship (Department)

Dates of proposed training \_\_\_\_\_ to \_\_\_\_\_

Name (Last, First, Middle) \_\_\_\_\_ Sex \_\_\_\_\_

Mailing Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

Permanent Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

Social Security Number \_\_\_\_\_

Age \_\_\_\_\_

Date of Birth \_\_\_\_\_

Place of Birth \_\_\_\_\_

U.S. Citizen  Yes  No

If not, citizen of what country? \_\_\_\_\_

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

ECFMG Number and results (Attach copy of certificate) \_\_\_\_\_

Visa Qualifying Examination? (Attach copy of results) \_\_\_\_\_

Have you entered/will you enter the United States under the Exchange Visitor Program  Yes  No

If not, give name of sponsor \_\_\_\_\_

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

If No, Please Explain \_\_\_\_\_

Marital Status \_\_\_\_\_

Name of spouse \_\_\_\_\_

Address \_\_\_\_\_

If not married, name of nearest of kin \_\_\_\_\_

Address \_\_\_\_\_

Military Status (Dates of Service or Draft Classification) \_\_\_\_\_

Curriculum Vitae	Institution	Dates	Degree	Major Subject	Honors
College					
Post Graduate					
** Medical College					

\*\* Graduates of medical colleges outside the United States or Canada must present credentials acceptable to the thomas Jefferson University Hospital and Educational Council for Foreign Medical Graduates and must submit their test scores before this application will be processed.  
 Contact: Educational Council for Foreign Medical Graduates, 3624 market Street, Philadelphia, PA. 19104.

# Application for Graduate Training

## Post Graduate Hospital Training

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

Specialty

Dates	to	Chief of Service or Staff
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## Residency Hospital (Name, Address)

Dates	to	Type of Residency
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Board Credit Years	Chief of Service
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## Additional Hospital Training (Name, Address)

Dates	to	Type of Training
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Board Credit Years	Chief of Preceptor
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Attach to this application a list of your scientific publications and a short description of any research experience which you have had prior to, during and after your medical education, including the names of the preceptors.

On the same sheet please list any honor society memberships, scholarships, honorary fellowships or awards which you have received, including the field of interest, stipends and dates of each.

### Please indicate the exams you have taken:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> NBME, Part I  | <input type="checkbox"/> NBME, Part II  | <input type="checkbox"/> NBME, Part III  |
| <input type="checkbox"/> USMLE, Step I | <input type="checkbox"/> USMLE, Step II | <input type="checkbox"/> USMLE, Step III |
| <input type="checkbox"/> Flex I        | <input type="checkbox"/> Flex II        |  |

### Please attach copies of exam results

License Number (attach copy of license)

Do you belong to a county medical society?  Yes  No Which one?

Did you belong to any undergraduate societies in medical college?

Are you a Diplomate of the National Board of Medical Examiners?

What employment positions have you held outside the field of medicine? Include dates and stipends.

## Application of Graduate Training

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

References	Name	Address	Years Acquaintance
1.			
2.			
3.			

In signing this application the physician submitting hereby certifies that to the best of (his/her) knowledge the information given is true. Appointments are contingent on the successful completion of the applicant's current year of graduate medical training, and the Thomas Jefferson University Hospital appointment process.

Dates this \_\_\_\_\_ day of \_\_\_\_\_, 19 \_\_\_\_\_, at (city, state) \_\_\_\_\_

Signed \_\_\_\_\_

**Mail To:** Chairman, Department of \_\_\_\_\_, Thomas Jefferson University Hospital, Phila., PA 19107

**AREA BELOW NOT TO BE FILLED IN BY APPLICANT**

To the Hospital Director:

I am herewith forwarding to you the application of \_\_\_\_\_  
Applicant's Name

for a \_\_\_\_\_ in \_\_\_\_\_, to be considered by the House Staff Committee.  
Residency/Fellowship Specialty

I hereby recommend acceptance of the above applicant for one year

a. from \_\_\_\_\_ to \_\_\_\_\_

b. Stipend to be \_\_\_\_\_ per annum.

c. Stipend payable form (Name of Fund, Grant, etc.) \_\_\_\_\_

d. The applicant is a  First  Second  Third  Fourth  Fifth  Sixth year resident

Signed \_\_\_\_\_

Date \_\_\_\_\_ Chairman, Department of \_\_\_\_\_