# *CHECKLIST FOR PROCESSING HOUSE STAFF APPLICATIONS*

_____ ***Cover letter must include the following***

- the applicant's name, dates of appointment and level requested, and **must be signed by the department Chairman**
- the applicant has been interviewed and evaluated by the members of the department
- the applicant's credentials have been reviewed by the departmental graduate medical education committee and has met departmental and institutional standards of clinical and academic excellence
- the applicant has been recommended for approval by the graduate medical education committee of the department
- indicate source of funding, i.e. hospital, grant, etc.

_____ ***Copy of ERAS or other matched application with photograph***

_____ ***Medical School transcript/Dean's letter***.

_____ ***Three letters of recommendation***

- Dean's letter counts as one of the three letters.
- If the applicant is in a current training program, ***one of the letters must be from the current Program Director*** .
- House staff who are starting at a PGY 2 level, there must be one **current** letter of recommendation (written within the last 12 months) from an attending during their internship year. (Letters from their 4th year of medical school do not fill this requirement.)
- Applicants who have been in practice must provide a letter of recommendation from the chief of staff of the hospital where they are currently practicing or from the county medical or osteopathic society.

_____ ***A CV is required*** for applicants and should **include all activities since graduation from medical school.**

_____ ***Copies of examination scores***:

Applicants entering as PGY 1 or PGY 2 must have the following:

- USMLE Step 1 and Step 2 (Clinical Knowledge and Clinical Skills)

**OR**

- COMLEX Level 1 and Level 2 (Cognitive Evaluation and Performance Evaluation)

Applicants entering as PGY 3 or above must have the following:

- USMLE Step 1, Step 2 (Clinical Knowledge and Clinical Skills) and Step 3

**OR**

- COMLEX Level 1, Level 2 Cognitive Evaluation and Performance Evaluation and Level 3

National Boards and FLEX are also accepted

_____ ***Copies of any unrestricted licenses*** held by the applicant.

_____ ***Provide evidence of a Valid Visa*** for alien graduates of foreign medical schools.

_____ ***Copy of the ECFMG <u>certificate</u>*** for all graduates of foreign medical schools. A status report is not acceptable.

***THE COMPLETED APPLICATION AND SUPPORTING CREDENTIALS MUST BE SUBMITTED TO THE HOUSE STAFF OFFICE AT LEAST 90 DAYS PRIOR TO THE START OF THE RESIDENT'S OR CLINICAL FELLOW'S TRAINING PROGRAM***

Jefferson University Hospitals

# *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 letters of recommendation be sent to the program to which you are applying as follows:
   - additional recommendations (Dean's Letter counts as Letter of Recommendation)

## Residency or Fellowship Request

| Department | Dates of Proposed Training |
|---|---|
| | |

## 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 | Degree |
|---|---|---|
| | to | |

## Medical School Education

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

## Current Post Graduate Hospital Training

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

| Specialty | Dates of training<br>to |
|---|---|
| Board Credit Year | Program Director |

**Residency Hospital (Name, Address)**

| Type of Residency | Dates of training<br>to |
|---|---|
| Board Credit Years | Program Director |

**Additional Hospital Training (Name, Address)**

| Type of Training | Dates of training<br>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<br>1. | Title | Years of Acquaintance | Telephone |
|---|---|---|---|
| Address (Street, City, State, Zip/Postal Code) | | Email | |
| Name<br>2. | Title | Years of Acquaintance | Telephone |
| Address (Street, City, State, Zip/Postal Code) | | Email | |
| Name<br>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 _____