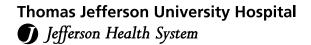
Thomas Jefferson University Hospital Jefferson Health System										
Application for Graduate Training							PLEASE MOUNT HERE			
For Residency (Department)						A SMALL RECENT PHOTOGRAPH				
For Fellowship (Department)										
Dates of proposed training										
Name (Last, First, Middle) Sex										
Mailing Address						Telephone Number				
Permanent Address					Telephone Number					
Social Security Number			je	Date of	Birth		Place of Birth			
U.S. Citizen	U.S. Citizen									
Type of visa on which you	u have entered/	you will enter	the United States	(Educatio	n, Immigrant,	Other)				
ECFMG Number and results (Attach copy of certificate) Visa Qualifying					Examination? (Attach copy of results)					
Have you entered/will you	u enter the Unit	ed States unde	er the Exchange V	isitor Prog	gram	Yes	□ No			
If not, give name of spon	sor									
Can you perform the esse	ential functions	of your reside	ncy position with	or withou	t reasonable a	iccommo	odation?	□ No		
If No, Please Explain										
Marital Status Name of spouse				Address						
If not married, name of nearest of kin				Address						
Military Status (Dates of S	Service or Draft	Classification)								
			1					T		
Curriculum Vitae	Curriculum Vitae Institution		Dates		egree	Ma	ajor 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 Hos	pital Training	
First Post Graduate y	ear or Internship Hospita	l (Name, Address)
Specialty		
Dates	to	Chief of Service or Staff
Decidency Heavital /N		
Residency Hospital (N	vaille, Address)	
Dates	to	Type of Residency
Board Credit Years		Chief of Service
Additional Hospital T	raining (Name, Address)	
Dates	to	Type of Training
Board Credit Years		Chief of Preceptor
Attach to this application	on a list of your scientific pu ation, including the names o	 ublications and a short description of any research experience which you have had prior to, during and of the preceptors.
On the same sheet plea interest, stipends and d	ase list any honor society molates of each.	emberships, scholarships, honorary fellowships or awards which you have received, including the field o
Please indicate the ex	xams you have taken:	
□ NBME, Part I	☐ NBME, Part II	□ NBME, Part III
☐ USMLE, Step I	☐ USMLE, Step II	□ USMLE, Step III
☐ Flex I	☐ Flex II	
Please attach copies	of exam results	
License Number (attach	n copy of license)	
Do you belong to a cou	unty medical society?	Yes No Which one?
Did you belong to any	undergraduate societies in r	nedical college?
Are you a Diplomate of	f the National Board of Med	dical Examiners?
What employment posi	itions have you held outside	the field of medicine? Include dates and stipends.

Thomas Jefferson University Hospital • Jefferson Health System

Application of Graduate Training

List below t	he names and addresses	of three profession	onal references, at	least one of whom	is a medical co	ollege faculty	reference.	
References	Name	Addre	ss				Years Acquaintance	
1.								
2.								
3.								
In signing thi contingent o appointment	s application the physician : n the successful completion process.	submitting hereby c of the applicant's o	ertifies that to the b current year of gradu	est of (his/her) know uate medical training	ledge the inform , and the Thoma	nation given is s Jefferson Un	true. Appointments are iversity Hospital	
Dates this	day of _		20	at (city state)				
	day or _		_,					
			Signed					
Mail To: Cha	airman, Department of			, Tł	nomas Jefferson	University Hos	pital, Phila., PA 19107	
AREA BELO	W NOT TO BE FILLED IN	BY APPLICANT						
To the Hospi	tal Director:							
I am herewit	h forwarding to you the app	olication of						
					t's Name			
for a	Residency/Fellowship	in			, to be conside	ered by the Ho	ouse Staff Committee.	
	Residency/Fellowship		Specialty					
I hereby reco	mmend acceptance of the	above applicant for	one year					
a. from		to						
b. Stipend to	be	per annum.						
6.1								
c. Stipend pa	yable form (Name of Fund,	Grant, etc.)			_			
d. The applic	ant is a	☐ Second	☐ Third	☐ Fourth	☐ Fifth	☐ Sixth	year resident	
			Signed					
Date			Chairman, Department of					
			,					

Please send in **TWO** complete copies of the <u>Application for Graduate Training</u>, and **ONE** copy each of the following:

- Three letters of recommendation—one from the surgical residency program director.
- Medical school transcripts.
- Brief personal statement.
- E-mail address.