

## APPLICATION FOR RESIDENCY / FELLOWSHIP

1. Name : \_\_\_\_\_  

Last
First
Middle

2. Social Security # : \_\_\_\_\_ 3. Date of Birth : \_\_\_\_\_

4. Program : \_\_\_\_\_ Application for : \_\_\_\_\_  

Year

5. Shall participate in NRMP match :  Yes  No or AOA match  Yes  No

6. Present Address: \_\_\_\_\_  

Street
  
 \_\_\_\_\_  

City
State
Country
Zip

7. Present phone numbers : Day ( \_\_\_\_\_ ) \_\_\_\_\_  
 Evening ( \_\_\_\_\_ ) \_\_\_\_\_

8. Permanent Address : (Name of person through whom I can always be contacted.)  
 \_\_\_\_\_  
 \_\_\_\_\_  

Street
  
 \_\_\_\_\_  

City
State
Country
Zip

9. Permanent phone number : ( \_\_\_\_\_ ) \_\_\_\_\_

10. Citizenship :  U.S.  Other : \_\_\_\_\_

11. Visa status (if applicable) :  Permanent Immigrant # : \_\_\_\_\_  
 Temporary (Specify) :  J-1  H-1  Other : \_\_\_\_\_

12. Medical Education  
 Medical School : \_\_\_\_\_  
 \_\_\_\_\_  

City
State

Dates of attendance : From : \_\_\_\_\_ To : \_\_\_\_\_  

Mo / Yr.
Mo / Yr.

Date of (anticipated) graduation : \_\_\_\_\_ Degree : \_\_\_\_\_  

Mo / Yr.

Other professional medical schools attended : \_\_\_\_\_  
 \_\_\_\_\_  

City
State

Dates of attendance : From : \_\_\_\_\_ To : \_\_\_\_\_  

Mo / Yr.
Mo / Yr.

Name  
Last  
First  
Middle  
Application for: (Specialty) (Year)

13. I have passed the examinations checked below with the scores and the dates indicated :

NBOME	Part I	_____	_____	USMLE	STEP I	_____	_____	
		Score	Date				Score	Date
	Part II	_____	_____		STEP 2	_____	_____	
		Score	Date			Score	Date	
	Part III	_____	_____	STEP 3	_____	_____		
		Score	Date			Score	Date	

14. List states in which you hold license to practice medicine and indicate each Medical License Number, date issued, and whether license is current.

State	License #	Date issued	Is license current?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

15. Undergraduate Education :

Undergraduate College(s)	From :	To :	Major :	Degree :
_____	_____	_____	_____	_____
Name	Mo / Yr.	Mo / Yr.		If any
_____				
City	State			
_____	_____	_____	_____	_____
Name	Mo / Yr.	Mo / Yr.		If any
_____				
City	State			

16. Graduate Education

Graduate College(s)	From	To	Area of Study	Grad. Degree
_____	_____	_____	_____	_____
Name	Mo / Yr.	Mo / Yr.		If any
_____				
City	State			
_____	_____	_____	_____	_____
Name	Mo / Yr.	Mo / Yr.		If any
_____				
City	State			

17. List residency training completed in the United States.

Dates (MO/YR) (MO/YR)	Name of Hospital	Location of Hospital	Specialty
_____ To _____	_____	_____	_____
_____ To _____	_____	_____	_____
_____ To _____	_____	_____	_____

18. Have you ever pleaded guilty to, or been convicted of, any violation other than a misdemeanor or summary offense?  Yes  No  
If you answer "Yes"; please explain on a separate sheet and attach.
- Have you ever been dismissed or asked to leave a position?  Yes  No  
If you answer "Yes"; please explain on a separate sheet and attach.

19. In addition to a letter from the Office of the Dean of the Medical College from which I will graduate, the following individuals, who know my qualifications well, have been asked to write references for me.

Name and Title	Phone
Address	
Name and Title	Phone
Address	
Name and Title	Phone
Address	

20. Please attach a curriculum vitae, accounting for ALL time since graduation from Medical School.

The Maternal Fetal Medicine of Central PA is a Drug-Free workplace and as such as a condition of employment is that the unlawful manufacture, distribution, dispensation, possession or use of controlled substances or alcohol is prohibited on business/hospital property or while conducting hospital/practice business.

(Check One)

I hereby waive access to my reference letters and will so inform the authors.

I desire access to my reference letters and will so inform the authors.

I have read all the statements and questions on this application and I understand the instructions for the completion of this application. I hereby certify that the forgoing statements are true and correct. I understand that the program may consider any false or incomplete statement on this application sufficient cause for rejection of this application or for subsequent dismissal.

I understand and authorize the program to undertake all necessary and appropriate background investigations for consideration of employment and continued employment. I further authorize and release from all liability or responsibility all persons and corporations requesting or supplying such information.

I understand that commencement of employment required the completion of a medical examination.

I understand that if I am offered employment, the MFM of Central Pa will require me to produce certain documents within three business days of my hire date in order to comply with the Immigration Reform and Control Act of 1986. I further understand that any offer of employment is contingent upon providing the appropriate documents.

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Signature of Applicant

Date

Note: The signature and date on each application must be original

It is the policy of the MFM of Central PA Fellowship Program to conform to the laws of the United States and the Commonwealth of Pennsylvania and not to discriminate against applicants or employees with regard to their race, color, religion, religious creed, ancestry, national origin, sex, sexual orientation, age or disability.