



327 BEACH 19TH STREET
 FAR ROCKAWAY, NEW YORK 11691

DEPARTMENT OF INTERNAL MEDICINE
MEDICAL RESIDENCY TRAINING PROGRAM APPLICATION

I. APPLICATION FOR: PGY I [] PGY II [] PGY III []
 NRMP Match Participant: YES [] NO [] NRMP#: _____
 NAME _____
 LAST FIRST MIDDLE
 ADDRESS _____
 STREET CITY STATE/ZIP
 PHONE (____) _____ DATE OF BIRTH _____ SEX: M [] F []
 E-MAIL ADDRESS: _____

MARRIED OR SINGLE _____ SOCIAL SECURITY #: _____
 CITIZENSHIP: U.S. [] OTHER: _____ PLACE OF BIRTH: _____
 IF APPLICABLE: VISA STATUS: PERMANENT _____ TEMPORARY (specify) _____

II. COLLEGE _____ DEGREE _____ MTH/YR _____ MAJOR _____
 GRADUATE SCHOOL _____ DEGREE _____ MTH/YR _____ MAJOR _____
 MEDICAL SCHOOL _____ DEGREE _____ MTH/YR _____ MAJOR _____
 LICENSE: STATE(S) _____ YEAR(S) _____ NUMBER(S) _____

U.S.M.L.E. STEP 1 SCORE _____ # OF ATTEMPTS _____ DATE PASSED _____
 STEP 2 SCORE _____ # OF ATTEMPTS _____ DATE PASSED _____
 STEP 3 SCORE _____ # OF ATTEMPTS _____ DATE PASSED _____

NATIONAL BOARDS PART 1 SCORE _____ # OF ATTEMPTS _____ DATE PASSED _____
 PART 2 SCORE _____ # OF ATTEMPTS _____ DATE PASSED _____
 PART 3 SCORE _____ # OF ATTEMPTS _____ DATE PASSED _____

FMGEM BASIC SCIENCE
 # _____ SCORE _____ # OF ATTEMPTS _____ DATE PASSED _____
 CLINICAL SCIENCE
 SCORE _____ # OF ATTEMPTS _____ DATE PASSED _____

ECFMG
 # _____ SCORE _____ # OF ATTEMPTS _____ DATE PASSED _____

FLEX # STEP 1 SCORE _____ # OF ATTEMPTS _____ DATE PASSED _____
 STEP 2 SCORE _____ # OF ATTEMPTS _____ DATE PASSED _____

FIFTH PATHWAY DIPLOMA _____ DATE OF COMPLETION _____

- III. DOCUMENTS AND REFERENCES: (Necessary for application to be considered)
1. TRANSCRIPT OF MEDICAL SCHOOL RECORDS (must be mailed to hospital directly from school)
 2. TWO LETTERS OF RECOMMENDATION.
 3. LETTER FROM DEAN OF MEDICAL SCHOOL.
 4. DOCUMENTATION OF SCORES ON EXAMS ABOVE.
 5. ECFMG CERTIFICATE.
 6. CERTIFIED TRANSLATION OF MEDICAL SCHOOL RECORDS AND DIPLOMA.
 7. FIFTH PATHWAY DIPLOMA (with certified translation).

IV. **PROFESSIONAL EXPERIENCE:** {List all hospitals and medical facilities with which you have ever been affiliated). Please account for all of your time since graduation from medical school.

<u>HOSPITAL/FACILITY</u>	<u>NATURE OF STUDY/EMPLOYMENT</u>	<u>INCLUSIVE DATES</u>
--------------------------	-----------------------------------	------------------------

V. **AUTHORIZATION AND RELEASE FROM LIABILITY**

For the purposes of this Authorization, the term "Hospital" means and includes Episcopal Health Services, Inc., St. John's Episcopal Hospital, South Shore Division, and their directors, officers, trustees, administrators, agents, attorneys, employees, member of the Medical and Dental Staff, medical residents and all persons affiliated in any manner with the Hospital's Medical Residency Training program.

I hereby authorize the Hospital to consult with Residency Program directors or their designees, faculty members, residents, administrators, employees, and members of the medical staffs of this and other hospitals or health care facilities with which the applicant or appointee is or has been associated, and with others who may have information bearing on the applicant's or appointee's academic performance, quality of patient care, professional qualifications, credentials, clinical competence, character, mental or emotional stability, mental or physical condition, ethics behavior, disciplinary action or any other matter, as well as to inspect all records and documents that may be material to such questions.

I hereby grant full immunity to the Hospital and release the Hospital from any liability for all acts, investigations, statements, evaluations, reports, communications, recommendations, opinions or application disclosures made, done or requested in connection with evaluating (I) my applications for participation in the Medical Residency Training Program, and (II) my eligibility and/or qualifications to continue in the Medical Residency Training Program.

VI. Do you have any physical or mental condition which may impair or prevent you from performing the essential functions of a medical resident, including the safe and competent rendering of patient care and treatment? **Yes [] No []**
(Your answer to this question will not affect the processing of this applications.)

VII. I understand and agree that any material misstatement or misrepresentation in or omission from this Application shall constitute cause for denial of the application and/or dismissal from the Medical Residency Training Program.

AVAILABLE FOR INTERVIEW: (specify months of availability) _____

SIGNED: _____ **DATE** _____

MAIL OR DELIVER THIS APPLICATION TO DEPARTMENT OF MEDICINE AT ABOVE ADDRESS.

PLEASE ATTACH A SMALL PHOTOGRAPH.