

Return with supporting documents to:
CLEVELAND CLINIC FLORIDA
GRADUATE MEDICAL EDUCATION
2950 Cleveland Clinic Boulevard
Weston, Florida 33331
Phone: 954/659-6211
Fax: 954/659-6216
Toll Free Number: 1-866-293-7866 ext. 56211

APPLICATION FOR CLINICAL RESIDENCY ☐ or FELLOWSHIP ☐

Please Print or Type

APPLICATION FOR RESIDENCY/FELLOWSHIP IN _____

TO BEGIN ON _____ **AT GRADUATE LEVEL** _____

Match Number (if applicable) _____ Medical School NRMP Code _____

PERSONAL DATA

Last Name	First Name	Middle Name	Social Security Number
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Present Mailing Address (Street, City, State, Country, Postal Code)	Area Code/Home Phone Number
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Permanent Mailing Address (Street, City, State, Country, Postal Code)

Area Code/Work Phone Number	Area Code/Fax Number	e-mail address	Date of Birth
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EDUCATION - Name and Location of School - Dates of Attendance and Degree Obtained

College or University	Address	Dates Attended	Degree
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Advanced Degree School	Address	Dates Attended	Degree
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Medical School	Address	Dates Attended	Degree
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United States Medical Licensing Examination: _____
Step I Step II Step III

HOSPITAL EXPERIENCE (Please list all previous training. Use additional sheet if necessary)

GL-1 year	Address	Dates Attended	Type
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Residency-Hospital	Address	Dates Attended	Specialty
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Residency-Hospital	Address	Dates Attended	Specialty
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ADDITIONAL INFORMATION:

Are you aware of any limitation that would prevent you from performing the duties of the training position for which you are applying? ☐ No

☐ Yes Explain: _____

Military Status (U.S.A.) present status and service record:

Do you have a military or USPHS commitment? ☐ No ☐ Yes

If yes: Starting _____ for _____ years in _____ (Branch of service)

Do you hold a Reserve commission? ☐ No ☐ Yes Branch _____ Rank _____

Are you required to attend reserve meetings? ☐ No ☐ Yes Summer training camp? _____

Do you have a Florida Medical License? If yes, please submit a copy of your medical license.

☐ No ☐ Yes Number: _____ Permanent: _____ Training Certificate: _____

List states where you hold permanent licensure - include number and expiration date:

Have you ever been denied a medical license or had a license revoked? ☐ No ☐ Yes

If yes, explain: _____

Do you have a Drug Enforcement Administration (DEA) registration in Florida? If yes, please submit a copy of your DEA certificate.

☐ No ☐ Yes DEA Number: _____

International Medical Graduates Only:

Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ☐ No ☐ Yes

Certificate number: _____ Certification valid through date: _____

Examination Taken and Test Scores

VQE 1 _____ 2 _____

NBME 1 _____ 2 _____ 3 _____

FMGEMS 1 _____ 2 _____

USMLE: 1 _____ 2 _____ 3 _____

Are you a citizen of the United States? ☐ Yes ☐ No Permanent resident? ☐ Yes ☐ No A# _____

If not, are you currently in the U.S.? If so, what is your status?

☐ J-1 Visa ☐ Research ☐ Clinical How long? _____

☐ H1B Visa ☐ Research ☐ Clinical How long? _____

☐ Other _____ ☐ Exp. Date _____

If not in the U.S., what type of Visa may we advise you about: ☐ J-1 ☐ H-1B

References and Supporting Documents:

PGY1: Please submit a personal statement and ask at least two physicians who have supervised you in a clinical setting to send letters in support of your application. Please ask your dean to send a letter of commendation, including a transcript. Also, a statement of your class standing, if available.

PGYII and above: Please submit a personal statement and three letters of recommendation two of which must be from physicians who have supervised you in a clinical setting to send in support of your application. Your completed application will include this application form, curriculum vitae, and a copy of letter of commendation from medical school dean, medical school diploma, and certificate (or other validation) of all previous training.

Fellowship and Registered International Medical Graduates: In addition to the above requirements, send a **certified copy** of your ECFMG certificate and qualifying exam results.

DO NOT SEND ORIGINAL DOCUMENTS. NO DOCUMENTS OR REPRINTS WILL BE RETURNED.

The policy of Cleveland Clinic Florida is to provide equal opportunity to all of our employees and applicants for employment. Decisions concerning employment, transfers and promotions are all made upon the basis of the best qualified candidate without regard to color, race, religion, national origin, age, sex, handicapped status, ancestry or status as a disabled or Vietnam era veteran

I certify that the information given on this form and attached is true, accurate and complete.

Date _____

Signature of Applicant

FOR CLEVELAND CLINIC FLORIDA USE ONLY:

Approved by:

Department Program Director or Supervising Physician

Chairman, Graduate Medical Education Committee