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

_____

Present Mailing Address (Street, City, State, Country, Postal Code) Area Code/Home Phone Number

_____

Permanent Mailing Address (Street, City, State, Country, Postal Code)

_____

Area Code/Work Phone Number Area Code/Fax Number e-mail address Date of Birth

EDUCATION - Name and Location of School - Dates of Attendance and Degree Obtained

_____

College or University Address Dates Attended Degree

_____

Advanced Degree School Address Dates Attended Degree

_____

Medical School Address Dates Attended Degree

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

_____

Residency-Hospital Address Dates Attended Specialty

_____

Residency-Hospital Address Dates Attended Specialty

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