

**APPLICATION FOR GRADUATE MEDICAL EDUCATION AT THE PUBLIC HEALTH TRUST'S  
 JACKSON MEMORIAL HOSPITAL AND RELATED FACILITIES**

Date \_\_\_\_\_

Indicate the department to which you are applying \_\_\_\_\_  
 Circle one: PGY 1 2 3 4 5 6 7

**1. PERSONAL DATA:**

Name in full \_\_\_\_\_

First Middle Last

Current mailing address \_\_\_\_\_

Street City State

Telephone: \_\_\_\_\_ e-mail \_\_\_\_\_

Zip Code area code

Permanent address if different from current \_\_\_\_\_

Street City State Zip Code

Place of Birth \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_ (if you do not have a Social Security number, one must be obtained before reporting for duty as resident.)

Are you a U.S. citizen? Yes/No If no, current status or visa \_\_\_\_\_

**2. EDUCATION**

Medical School \_\_\_\_\_

Name Degree

Location (City and State) Date or (Date Expected)

List chronologically your activities from the time of graduation from Medical School to present. Specify type of post-graduate training, if any.

FROM	TO	ACTIVITY	PLACE	DEGREE, IF ANY

(If additional space is required, please use separate sheet of paper)

**3. EXPERIENCE**

Special Clinical and/or Research experience \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Professional practice, location and dates \_\_\_\_\_

\_\_\_\_\_

Memberships in professional societies and list any publications \_\_\_\_\_

\_\_\_\_\_

(Use separate sheet of paper if needed)

**4. MEDICAL LICENSURE AND CERTIFICATION (if applicable)**

Date and Results of National Boards Examinations or F.L.E.X. (please include copy of results)

\_\_\_\_\_

Attach copies of all State Licenses issued to you.

Have you ever had an application for medical licensure denied? \_\_\_\_\_. If so, state the date, circumstances, and State where your application was denied.

\_\_\_\_\_

\_\_\_\_\_

Have you ever had a medical license revoked? \_\_\_\_\_. If so, state date, circumstances and State where the license was revoked. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Since your sixteenth birthday, have you ever been convicted of a felonious offense or are there felony charges currently pending against you? \_\_\_\_\_

If so, indicate as to the court involved, nature of offense, disposition or current status of the case and date of case.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**5. FOREIGN MEDICAL SCHOOL GRADUATES ONLY**

Citizenship and Date \_\_\_\_\_ (if not U.S. Citizen,

type of Visa) \_\_\_\_\_. If on a J.1 exchange

visitors visa, give country \_\_\_\_\_. Have you passed your Foreign Medical

Graduates Examination in the Medical Sciences (FMGEMS)? \_\_\_\_\_

Score on Basic Sciences \_\_\_\_ Clinical Sciences \_\_\_\_ English \_\_\_\_ Pass/Fail (Circle one).

Give number and indicate type of certificate \_\_\_\_\_ Standard \_\_\_\_\_ Interim \_\_\_\_\_

**6. A minimum of three letters of Reference is required: (One should be from the Dean of your medical School; and two from physicians who have observed you or supervised you in recent training programs. If you have had previous post-graduate training, one letter must be from your former program director).**

List below the names of your three references and ask them to correspond directly to the Chief of Program Director of the respective department in which you desire to residency. Each Chief and Program Director is located at Jackson Memorial Medical Center, 1611 N.W. 12<sup>th</sup> Avenue, Miami, Florida 33136.

1. \_\_\_\_\_  
Name Address
2. \_\_\_\_\_  
Name Address
3. \_\_\_\_\_  
Name Address

Any Others:

- \_\_\_\_\_
- Name Address
- \_\_\_\_\_
- Name Address

**7. PLANS AFTER PGY-1**

What are your immediate and long range plans after PGY-1 (i.e. Military Service, residency, specialty, practice, academic medicine, etc.) Please indicate if you desire a one-year appointment only.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**8. AGREEMENT**

If I am offered an appointment by the Public Health Trust to serve at the University of Miami/Jackson Memorial Hospital Medical Center and I accept same, I will abide by all the Rules and Regulations of the included Hospitals for members of the House Staff including but not limited to Medical Staff Bylaws, Medical Staff Rules and Regulations, Public Health Trust Policies and Procedures and the Collective Bargaining Agreement between the Public Health Trust and the Committee of Interns and Residents and will to the best of my ability fulfill the obligations of my assignment for the full term of my appointment.

Anticipated Start Date \_\_\_\_\_ Anticipated Ending Date \_\_\_\_\_

**9. ENCLOSE WITH THE COMPLETED APPLICATION THE FOLLOWING:**

- a) Transcript of Medical School Scholastic Record
- b) Copy of State Licenses
- c) Flex or National Boards results
- d) Valid ECFMG Certificate, or ECFMG documentation

**10. "I hereby declare that I have examined this application; and to the best of my knowledge and belief, it is true, correct, and complete."**

Signature \_\_\_\_\_  
Applicant

Notary Public \_\_\_\_\_

My Commission Expires \_\_\_\_\_ 20\_\_

Seal

NOTE: A three hundred word typed or handwritten biographical sketch and a personal interview may be required by some departments.

Mail entire contents to the Chief or Program Director at

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_