

**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 :

<b>NBOME</b>	Part I _____	_____	<b>USMLE</b>	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 Western Pennsylvania Hospital is a Drug-Free workplace and as such, a condition of employment is that the unlawful manufacture, distribution, dispensation, possession or use of Controlled Substances or Alcohol is prohibited on Hospital property or while conducting Hospital 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 foregoing statements are true and correct. I understand that the Hospital 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 Hospital 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 requires the completion of a medical examination given by the Hospital.

I understand that if I am offered employment, The Western Pennsylvania Hospital will require me to produce certain documents within three (3) 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***

<p>Attach Recent Photograph</p> <p>Optional</p>
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It is the policy of The Western Pennsylvania Hospital 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.