# Griffin Hospital Advanced Preventive Medicine Residency Program Application Form

## Personal Information

***Contact Information***

First Name*: _____ Middle Name: _____ Last Name*: _____

Previous Last Name: _____ Suffix: _____ Preferred Last Name: _____

Last 4 digits of SSN: _____

Preferred Phone*: _____ Mobile Phone: _____

Alternate Phone: _____ FAX: _____ Pager: _____

Email*: _____

***Address***

**Current Mailing Address**

Address 1*: _____

Address 2: _____

Country*: _____ State: _____ *(Required for U.S. & Canadian addresses)*

City*: _____ Postal Code: _____

Is your permanent address the same as your current mailing address?* ☐ Yes ☐ No

**Permanent Address** (*if different*)

Address 1*: _____

Address 2: _____

Country*: _____ State: _____ *(Required for U.S. & Canadian addresses)*

City*: _____ Postal Code: _____

***Emergency Contact Information***

Name: _____

Relationship: _____

Telephone: _____ Email Address: _____

***Citizenship Information***

Are you a U.S. citizen?* ☐ Yes ☐ No

If yes, are you a citizen of a country in addition to the United States? ☐ Yes ☐ No

If yes, indicate your country of dual citizenship (other than the United States): _____

If you are a foreign national currently in the U.S. with valid visa status, indicate your current visa/employment authorization status:

_____

If you are a foreign national, outside the U.S. or currently in the U.S. with a valid visa status, please respond:

Will you need visa sponsorship through the ECFMG (J-1) or the teaching hospital (H-1B) in order to participate in U.S. residency and/or fellowship training? ☐ Yes ☐ No

If yes, please select the visa(s) you would like to apply for. Select all that apply. ☐ H-1B ☐ J-1

Eligibility for ECFMG J-1 visa sponsorship is not to be presumed. For details on ECFMG J-1 requirements and restrictions, please see refer to ECFMG/EVSP website at.ecfmg.org/evsp/requirements.html.

If no, expected visa/employment authorization status (the visa status you expect to secure with employment authorization to participate in a program):_____

***Match Information***

**NRMP Match**

I plan to participate in the NRMP match?* ☐ Yes ☐ No

If yes, NRMP ID: _____

Participating as a couple in NRMP: ☐ Yes ☐ No

If yes, Partner's Name:_____

Specialties pPartner is applying to: _____

**NMS Match**

I plan to participate in the NMS match?* ☐ Yes ☐ No

If yes, AOA Match Number (NMS Number): _____

Participating as a couple in the NMS: ☐ Yes ☐ No

If yes, Partner's Name:_____

Specialties pPartner is applying to: _____

**Urology Match**

AUA Member Number: _____

***Additional Information***

USMLE/ECFMG ID: _____

NBOME ID (Required for D.O. applicants): _____

AOA Member Number: _____

I am ACLS (Advanced Cardiovascular Life Support) certified in the U.S.A.: ☐ Yes ☐ No

If yes, ACLS Expiration Date: _____

I am PALS (Pediatric Advanced Life Support) certified in the U.S.A.: ☐ Yes ☐ No

If yes, PALS Expiration Date: _____

I am BLS (Basic Life Support) certified in the U.S.A.: ☐ Yes ☐ No

If yes, BLS Expiration Date: _____

Sigma Sigma Phi Status: _____

Alpha Omega Alpha Status: _____

Gold Humanism Honor Society Status: _____

# Biographic Information

***General***

Gender*: _____ Birth Place: _____ Birth Date: _____

***Self Identification***

If you reside in the European Union, do not answer this question. Please ignore this section.

This section allows you to indicate how you self-identify. If you prefer not to self-identify, please ignore this section.

How do you self-identify? Please select all that apply.

- ☐ Hispanic, Latino or of Spanish origin
  - ☐ Argentinean
  - ☐ Colombian
  - ☐ Cuban
  - ☐ Dominican
  - ☐ Mexican/Chicano
  - ☐ Peruvian
  - ☐ Puerto Rican
  - ☐ Other Hispanic: _____
- ☐ American Indian or Alaskan Native
  - ☐ Tribal affiliation: _____
- ☐ Asian
  - ☐ Bangladeshi
  - ☐ Cambodian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Indian
  - ☐ Indonesian
  - ☐ Japanese
  - ☐ Korean
  - ☐ Laotian
  - ☐ Pakistani
  - ☐ Taiwanese
  - ☐ Vietnamese
  - ☐ Other Asian: _____
- ☐ Black or African American
  - ☐ African American
  - ☐ Afro-Caribbean
  - ☐ African
  - ☐ Other Black: _____
- ☐ Native Hawaiian or Pacific Islander
  - ☐ Guamanian
  - ☐ Native Hawaiian
  - ☐ Samoan
  - ☐ Other Pacific Islander: _____
- ☐ White
- ☐ Other: _____

***Language Fluency***

Which languages do you speak? Select all that apply. For each language that you, including English, please to rate your proficiency in that language using the guidelines provided below.*

**Native/Functionally Native**: I converse easily and accurately in all types of situations. Native speakers, including highly educated, may think that I am a native speaker, too.

**Advanced**: I speak very accurately, and I understand other speakers very accurately. Native speakers have no problem understanding me, but they probably perceive that I am not a native speaker.

**Good**: I speak well enough to participate in most conversations. Native speakers notice some errors in my speech or my understanding, but my errors rarely cause misunderstanding. I have some difficulty communicating necessary health concepts.

**Fair**: I speak and understand well enough to have extended conversations about current events, work, family, or personal life. Native speakers notice many errors in my speech or my understanding. I have difficulty communicating about healthcare concepts.

**Basic**: I speak the language imperfectly and only to a limited degree and in limited situations. I have difficulty in or understanding extended conversations. I am unable to understand or communicate most healthcare concepts.

| **Language** | **Spoken Proficiency** | **Written Proficiency** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

***Military Information***

Are you committed to fulfill a U.S. military active duty service obligations/deferments?* ☐ Yes ☐ No

If yes, number of years remaining: _____ Branch: _____

Do you have any other service obligations? (e.g. - Military Reserves, Public Health/State programs, etc.) ☐ Yes ☐ No

If yes, describe:

***Additional Information***

Hobbies & Interests:

# Education

***Higher Education***

**Entry 1**

Institution*:_____

Location*: _____

Education Type*: _____

Field of Study*: _____

Degree expected or earned*: _____

Dates of Attendance: From (mm/dd/yyyy)_____To (mm/dd/yyyy)_____

**Entry 2**

Institution*:_____

Location*: _____

Education Type*: _____

Field of Study*: _____

Degree expected or earned*: _____

Dates of Attendance: From (mm/dd/yyyy)_____To (mm/dd/yyyy)_____

***Medical Education***

**Entry 1**

Country*: _____

Institution*: _____

Degree*: _____

Degree Month*: _____ Degree Year*: _____

Dates of Attendance: From (mm/dd/yyyy)_____ To (mm/dd/yyyy)_____

**Entry 2**

Country*: _____

Institution*: _____

Degree*: _____

Degree Month*: _____ Degree Year*: _____

Dates of Attendance: From (mm/dd/yyyy)_____ To (mm/dd/yyyy)_____

**Entry 3**

Country*: _____

Institution*: _____

Degree*: _____

Degree Month*: _____ Degree Year*: _____

Dates of Attendance: From (mm/dd/yyyy)_____ To (mm/dd/yyyy)_____

***Additional Information***

Membership in Honorary/Professional Societies:

Medical School Awards:

Other Awards/Accomplishments:

# Experience

***Training***

Please add any current or prior D.O. Internship, D.O. Residency, M.D. Residency or M.D. Fellowship in which you have trained, regardless of length of time spent in the training.

☐ None

**Training 1**

Type of Training*: _____

Specialty*: _____

Institution/Program*: _____

Country*: _____

State/Province: _____

City*: _____

Program Director*: _____

Supervisor*: _____

☐ Chief Resident

Dates of Residency/Fellowship: From (mm/dd/yyyy)_____To (mm/dd/yyyy)_____

Reason for Leaving:

**Training 2**

Type of Training*: _____

Specialty*: _____

Institution/Program*: _____

Country*: _____

State/Province: _____

City*: _____

Program Director*: _____

Supervisor*: _____

☐ Chief Resident

Dates of Residency/Fellowship: From (mm/dd/yyyy)_____To (mm/dd/yyyy)_____

Reason for Leaving:

**Training 3**

Type of Training*: _____

Specialty*: _____

Institution/Program*: _____

Country*: _____

State/Province: _____

City*: _____

Program Director*: _____

Supervisor*: _____

☐ Chief Resident

Dates of Residency/Fellowship: From (mm/dd/yyyy)_____To (mm/dd/yyyy)_____

Reason for Leaving:

**Training 4**

Type of Training*: _____

Specialty*: _____

Institution/Program*: _____

Country*: _____

State/Province: _____

City*: _____

Program Director*: _____

Supervisor*: _____

☐ Chief Resident

Dates of Residency/Fellowship: From (mm/dd/yyyy)_____To (mm/dd/yyyy)_____

Reason for Leaving:

**Training 5**

Type of Training*: _____

Specialty*: _____

Institution/Program*: _____

Country*: _____

State/Province: _____

City*: _____

Program Director*: _____

Supervisor*: _____

☐ Chief Resident

Dates of Residency/Fellowship: From (mm/dd/yyyy)_____To (mm/dd/yyyy)_____

Reason for Leaving:

***Experience***

Please add your additional experience. Clinical and Teaching experience should be treated as Work experiences. Include all unpaid extra -curricular activities and committees you have served on as a Volunteer experiences.

☐ None

**Experience 1**

Experience Type*: _____

Organization*: _____

Position*: _____

Supervisor: _____

Country*: _____

State/Province: _____

City*: _____

Average Hours/Week: _____

Description:

Reason for Leaving:

Dates of Experience*: From (mm /yyyy)_____To (mm /yyyy)_____

**Experience 2**

Experience Type*: _____

Organization*: _____

Position*: _____

Supervisor: _____

Country*: _____

State/Province: _____

City*: _____

Average Hours/Week: _____

Description:

Reason for Leaving:

Dates of Experience*: From (mm /yyyy)_____To (mm /yyyy)_____

**Experience 3**

Experience Type*: _____

Organization*: _____

Position*: _____

Supervisor: _____

Country*: _____

State/Province: _____

City*: _____

Average Hours/Week: _____

Description:

Reason for Leaving:

Dates of Experience*: From (mm /yyyy)_____To (mm /yyyy)_____

**Experience 4**

Experience Type*: _____

Organization*: _____

Position*: _____

Supervisor: _____

Country*: _____

State/Province: _____

City*: _____

Average Hours/Week: _____

Description:

Reason for Leaving:

Dates of Experience*: From (mm /yyyy)_____To (mm /yyyy)_____

**Experience 5**

Experience Type*: _____

Organization*: _____

Position*: _____

Supervisor: _____

Country*: _____

State/Province: _____

City*: _____

Average Hours/Week: _____

Description:

Reason for Leaving:

Dates of Experience*: From (mm /yyyy)_____To (mm /yyyy)_____

**Experience 6**

Experience Type*: _____

Organization*: _____

Position*: _____

Supervisor: _____

Country*: _____

State/Province: _____

City*: _____

Average Hours/Week: _____

Description:

Reason for Leaving:

Dates of Experience*: From (mm /yyyy)_____To (mm /yyyy)_____

**Experience 7**

Experience Type*: _____

Organization*: _____

Position*: _____

Supervisor: _____

Country*: _____

State/Province: _____

City*: _____

Average Hours/Week: _____

Description:

Reason for Leaving:

Dates of Experience*: From (mm /yyyy)_____To (mm /yyyy)_____

**Experience 8**

Experience Type*: _____

Organization*: _____

Position*: _____

Supervisor: _____

Country*: _____

State/Province: _____

City*: _____

Average Hours/Week: _____

Description:

Reason for Leaving:

Dates of Experience*: From (mm /yyyy)_____To (mm /yyyy)_____

**Experience 9**

Experience Type*: _____

Organization*: _____

Position*: _____

Supervisor: _____

Country*: _____

State/Province: _____

City*: _____

Average Hours/Week: _____

Description:

Reason for Leaving:

Dates of Experience*: From (mm /yyyy)_____To (mm /yyyy)_____

**Experience 10**

Experience Type*: _____

Organization*: _____

Position*: _____

Supervisor: _____

Country*: _____

State/Province: _____

City*: _____

Average Hours/Week: _____

Description:

Reason for Leaving:

Dates of Experience*: From (mm /yyyy)_____To (mm /yyyy)_____

***Additional Questions***

Was your medical education/training extended or interrupted?* ☐ Yes ☐ No

If yes, please provide details:

## Licensure

Please add an entry for any of your state medical licenses.

☐ None

**Entry 1**

State*: _____

License Type*: _____

License Number*: _____

Expiration Date*: Month:_____ Year:_____

**Entry 2**

State*: _____

License Type*: _____

License Number*: _____

Expiration Date*: Month:_____ Year:_____

***Additional Information***

Has your medical license ever been suspended/revoked/voluntarily terminated?* ☐ Yes ☐ No

If yes, please explain:

Have you been named in a malpractice case?* ☐ Yes ☐ No

If yes, please explain:

Is there anything in your past history that would limit your ability to be licensed or would limit your ability to receive hospital privileges?* ☐ Yes ☐ No

If yes, please explain:

Have you ever been convicted of a misdemeanor in the United States?* ☐ Yes ☐ No

If yes, please explain:

Have you ever been convicted of a felony in the United States?* ☐ Yes ☐ No

If yes, please explain:

Are you able to carry out the responsibilities of a resident or a fellow in the specialties and at the specific training programs to which you are applying, including the functional requirements, cognitive requirements, interpersonal and communication requirements with or without reasonable accommodations?* ☐ Yes ☐ No

If no, please list your limiting aspect(s):

Are you Board Certified?* ☐ Yes ☐ No

If yes, Board Name: _____

DEA Registration Number: _____

## Publications

Please attach list of publications, including:

- Peer Reviewed Journal Articles/Abstracts
- Peer Reviewed Journal Articles/Abstracts (Other than Published)
- Peer Reviewed Book Chapter
- Scientific Monograph
- Other Articles
- Poster Presentations
- Oral Presentations
- Non Peer Reviewed Online Publications

## Certification

By submitting this application, the candidate certifies that the information contained within is a complete and accurate record of the candidate's educational, clinical, and work experience. The candidate understands that any false or missing information may disqualify the candidate from consideration for a position, or if employed, may constitute cause for termination from the Residency Program.

Signature: _____ Date: _____

- Three letters of recommendation + Medical Student Performance Evaluation (MSPE) – We ask that the LORs include a summary of your activities and interest in Preventive Medicine/Public Health
- Personal Statement
- Curriculum Vitae
- Medical School Diploma
- USMLE Scores
- ECFMG Certificate