Application for Graduate Medical Education at the

Medical College of Georgia

Application should be returned to the training program director and/or Program Coordinator

Print or Type Application

Application Data

Date _____ Training Beginning Date _____

Specialty/Subspecialty Training Program _____

Postgraduate year of training applied for (check one):

- 1st year (PGY-1) · 2nd year (PGY-2) · 3rd year (PGY-3)
- 4th year (PGY-4) · 5th year (PGY-5)
- Other _____

Personal Data

Social Security Number _____ DOB _____ Race _____ Gender _____

First name _____ Middle name _____ Last name _____ (Jr. etc.) _____

Present Address (number and street) _____

City _____ State _____ Zip _____

Day Phone (Area Code/No.) _____ Evening Phone (Area Code/No.) _____

Permanent Address (number and street) _____

City _____ State _____ Zip _____

AAMC# _____ NRMP# _____

In Case of Emergency Contact:

Name _____ Relation _____

Address (number and street) _____

City _____ State _____ Zip _____

Day Phone (Area Code/No.) _____ Evening Phone (Area Code/No.) _____

Citizenship (Country) _____

If you are not a U.S. citizen, provide the following information:

Type of Visa _____ Expiration Date _____

Comments _____

Note: In general, H-1B visa is not accepted for Graduate Medical Education programs at the Medical College of Georgia at Augusta University. If you have any questions, please contact the GME Office.

Undergraduate Education

Name of College/University _____

City _____ State _____ Country _____

Degree _____

Dates: From Month/Day/Year _____ To Month/Day/Year _____

(Attach additional sheets, if necessary)

Medical Education

Name of School _____

City _____ State _____ Country _____

Degree _____

Dates: From Month/Day/Year _____ To Month/Day/Year _____

(Attach additional sheets, if necessary)

Previous Internship/Residency/Fellowship Training

(List each year of training separately, beginning with first year)

Name of Hospital _____

City _____ State _____ Country _____

Name of Program _____

PGY Level _____

Dates: From Month/Day/Year _____ To Month/Day/Year _____

Name of Hospital _____

City _____ State _____ Country _____

Name of Program _____

PGY Level _____

Dates: From Month/Day/Year _____ To Month/Day/Year _____

(continue on next page)

Previous Internship/Residency/Fellowship Training
(continued)

Name of Hospital

City State Country

Name of Program

PGY Level

Dates: From Month/Day/Year To Month/Day/Year

Name of Hospital

City State Country

Name of Program

PGY Level

Dates: From Month/Day/Year To Month/Day/Year

Name of Hospital

City State Country

Name of Program

PGY Level

Dates: From Month/Day/Year To Month/Day/Year Name of

Hospital

City State Country

Name of Program

PGY Level

Dates: From Month/Day/Year To Month/Day/Year

Name of Hospital

City State Country

Name of Program

PGY Level

Dates: From Month/Day/Year To Month/Day/Year

Name of Hospital

City State Country

Name of Program

PGY Level

Dates: From Month/Day/Year To Month/Day/Year

(Attach an additional sheet if more space is required. Please use same format)

Graduates of Foreign Medical Schools Only

ECFMG#

ECFMG Certificate valid through Month Day Year

A copy of your ECFMG certificate must be attached to this application. The certificate ***MUST*** be valid through the starting date of the program or valid indefinitely.

Licensure/DEA Registration

Do you hold a State Medical License? Circle Yes or No

If yes, please provide the type of license and number:

Do you have an NPI#? Circle Yes or No
If yes, please provide the NPI#:

Has your license in any jurisdiction ever been limited, suspended, surrendered, lapsed, or revoked?
❑ Yes ❑ No ❑ N/A
If yes, attach a full explanation to this application.

Have you ever been issued a federal DEA number? ❑ Yes ❑ No
If yes, provide number: _____

Has your federal DEA registration ever been limited, suspended, surrendered, lapsed, or revoked? ❑ Yes ❑ No ❑ N/A
If yes, attach a full explanation to this application.

Military Status

Have you ever performed active duty in the armed services?
❑ Yes ❑ No
If yes, list rank, branch of service and dates:

Are you a member of the Reserves or National Guard? ❑ Yes ❑ No
If yes, give branch and status:

Examinations

United States Medical Licensing Exam (USMLE)
Comprehensive Osteopathic Medical Licensing Exam (COMLEX)
Have you taken all or part of the USMLE/COMLEX? ❑ Yes ❑ No
If yes, check the appropriate space below and provide the information requested.

❑ USMLE/COMLEX Step 1 Date taken _____ Score _____

❑ USMLE/COMLEX Step 2 Date taken _____ Score _____

❑ USMLE/COMLEX Step 3 Date taken _____ Score _____

National Boards
Have you taken all or any part of the National Boards? ❑ Yes ❑ No
If yes, check the appropriate space below and provide the information requested. Name of the National Board(s) you have taken.

_____

❑ National Boards Part 1 Date taken _____ Composite Score _____

❑ National Boards Part 2 Date taken _____ Composite Score _____

❑ National Boards Part 3 Date taken _____ Composite Score _____

References

Please give the name, address, and phone number of three physicians who have knowledge of your experience, ability, educational accomplishments, and character. For ***internship*** applicants, this should include your dean and two members of the medical school faculty. For ***residency and fellowship*** applicants, this should include the Program Director on which you interned. For applicants coming from the ***military***, it should include your former chiefs, if possible.

_____
Name/Title

_____
Complete Address

_____

_____
Area Code/Phone No.

_____
Name/Title

_____
Complete Address

_____

_____
Area Code/Phone No.

_____
Name/Title

_____
Complete Address

_____

_____
Area Code/Phone No.

CPR Certification

Have you participated in either of the following training programs:

Basic Cardiac Life Support Training ❑ Yes ❑ No
Expiration Date _____

Advanced Cardiac Life Support Training ❑ Yes ❑ No
Expiration Date _____

Advanced Trauma Life Support ❑ Yes ❑ No
Expiration Date _____

Professional Sanctions/Charges/Violations

Are you now, or have you ever been, involved in any litigation, lawsuits, claims, or arbitration related to your professional activities? ❑ Yes ❑ No

Have judgements or settlements been made against you in professional liability cases or are you involved in any pending litigation? ❑ Yes ❑ No

Have you ever been denied liability insurance? ❑ Yes ❑ No

Has your membership or renewal thereof in any medical organization ever been revoked, suspended, diminished, or denied? ❑ Yes ❑ No

Have your privileges in any hospital ever been suspended, diminished, revoked, or not renewed? ❑ Yes ❑ No

Have you ever been charged with any crime, including DUI/DWI, other than minor traffic violations? ❑ Yes ❑ No

If your answer is YES to any of the above questions, please include a statement of explanation with this application.

Student Right to Know/Campus Security Act 1990

In accordance with the Student Right to Know and Campus Security Act of 1990, the Medical College of Georgia makes available, upon request, its annual security report which provides campus security information concerning crime statistics, crime reporting procedures, building security, campus police, crime prevention information, policies regarding the illegal use of alcohol or drugs, alcohol and drug abuse education programs and sexual assault programs. If you desire a copy of this report, please contact MCG Public Safety at (706) 721-2914.

Release Statement

I hereby state that the information provided by me in this application is true in all respects. I agree that if I am employed and information is found to be false, I am subject to dismissal. I hereby authorize my former employers and my references to furnish any information concerning my personal character, habits or employment records and hereby release all such persons from any liability and damages for having furnished such information to the Medical College of Georgia at AU.

_____
Applicant's Signature Date

Department Use Only

Complete the following prior to submitting application to the House Staff Office:

APPROVED FOR APPOINTMENT ❑ Yes ❑ No

CONTRACT PERIOD From: _____ To: _____

BEGINNING PGY LEVEL _____

_____
Program Director's Signature Date

An Affirmative Action/Equal Opportunity Educational Institution