MetroHealth

Graduate Medical Education
2500 MetroHealth Drive, A107 | Cleveland OH 44109

UNIVERSAL APPLICATION

Please return completed application and documents to the Program Coordinator

Program Applying for: _____ Training Year Applying for: _____

DEMOGRAPHICS:

Applicant Last Name _____ Applicant First Name _____ Middle (No Initial) _____

Degree ☐ MD ☐ DO ☐ DDS ☐ Other _____

Present Street Address _____ City _____ State _____ ZIP Code _____ Country _____

Cell Phone _____ Email Address _____

Permanent Address _____

City _____ State _____ ZIP Code _____ Country _____

Birth Date _____ Birth City _____

Birth State _____ Birth Country _____

Social Security Number _____ NPI (National Provider Identifier) _____

Gender ☐ Female ☐ Male

Ethnicity: ☐ White(Non-Hispanic) ☐ Black/African American (Non-Hispanic) ☐ Asian ☐ Hispanic/Latino
☐ Middle Eastern ☐ Native Hawaiian/Pacific Islander ☐ American Indian ☐ Other _____

SERVICE OBLIGATIONS: Do you have any commitment to fulfill U.S. Military service obligations? ☐ Yes ☐ No

If Yes: Describe_____

WORK AUTHORIZATION: Are you authorized to work in the U.S.? ☐ Yes ☐ No

If so, what is your status?

☐ US Citizen

☐ Exchange Visitor Visa (J-1) How long? _____

☐ H1B Visa How long? _____

☐ Other Exp. date _____

If not in the U.S., what type of Visa may we advise you about: ☐ J-1 ☐ H-1B

International Medical Graduates Only:

Are you certified by the ECFMG? ☐Yes ☐No Certificate number: _____ Certificate issue date: _____

EDUCATION:

College or University	City	State	Beginning	Ending	Major

Advanced Degree School	City	State	Beginning	Ending	Degree Granted

Medical School	City	State	Beginning	Ending	Degree Granted

Was your medical education/training extended or interrupted? Please explain any gaps of three or more months during your medical education and/or residency training? *attach explanation if necessary

☐ No ☐ Yes

CERTIFYING EXAMS: ☐ USMLE ☐ COMLEX

Step or Part 1	Step or Part 2 ck	Step or Part 2 cs	Step or Part 3

HOSPITAL/WORK EXPERIENCE: (Please list all previous training and work experience. Use additional sheet if necessary.)

#1

Specialty_____

Type: ☐ Internship ☐ Residency ☐ Fellowship ☐ Other Dates: From: _____ To: _____

Institution/Program: _____

City: _____ State/Province: _____ Country: _____ Years: _____

Program Director: _____ Supervisor: _____

#2

Specialty_____

Type: ☐ Internship ☐ Residency ☐ Fellowship ☐ Other Dates: From: _____ To: _____

Institution/Program: _____

City: _____ State/Province: _____ Country: _____ Years: _____

Program Director: _____ Supervisor: _____

#3

Specialty_____

Type: ☐ Internship ☐ Residency ☐ Fellowship ☐ Other Dates: From: _____ To: _____

Institution/Program: _____

City: _____ State/Province: _____ Country: _____ Years: _____

Program Director: _____ Supervisor: _____

#4

Specialty_____

Type: ☐ Internship ☐ Residency ☐ Fellowship ☐ Other Dates: From: _____ To: _____

Institution/Program: _____

City: _____ State/Province: _____ Country: _____ Years: _____

Program Director: _____ Supervisor: _____

LICENSURE: Do you currently hold a medical/dental/training license? ☐ Yes ☐ No

1. List states where you hold permanent licensure - include number and expiration date:

State	License Number	Expiration	State	License Number	Expiration

2. Have you ever been denied a medical license or had a license revoked? ☐ Yes ☐ No

If yes, explain: _____

3. BOARD CERTIFICATION: Are you Board Certified? ☐Yes ☐No

Board Name	Expiration
1._____	_____
2._____	_____

HAVE YOU EVER BEEN CONVICTED OF A MISDEANOR? ☐Yes ☐No
If Yes, please explain._____

HAVE YOU EVER BEEN CONVICTED OF A FELONY? ☐Yes ☐No
If Yes, please explain._____

Are you able to carry out the responsibilities of a resident or 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, and attendance requirements with or without reasonable accommodations? ☐Yes ☐No

REFERENCES AND SUPPORTING DOCUMENTS:

PGYI: Please submit a CV, Deans Letter, USMLE (or COMLEX) score reports, Medical School Transcripts, and at least two letters of recommendation from physicians whom have supervised you in a clinical setting.

PGYII/above: Please submit a CV, Deans letter, USMLE (or COMLEX) score reports, Medical School Diploma, a letter of support from your residency program director and at least two letters of recommendation from other physicians whom have supervised you in a clinical setting as well as certificate (or other validation) of all previous training.

INTERNATIONAL GRADUATES:
In addition to the requirements above, please send a certified copy of your ECFMG certificate.

REFERENCES AND SUPPORTING DOCUMENTS WILL NOT BE RETURNED.

The policy of MetroHealth Medical Center is to provide equal opportunity to all of our employees and applicants for employment. Decisions concerning employment, transfers and promotions are made upon the basis of the best qualified candidate without regard to color, race, religion, national origin, age, sex, sexual orientation, marital status, ancestry, status as a disabled or Vietnam era veteran or any other characteristic protected by law.

I certify that the information contained within this application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position; may result in an investigation by MetroHealth Medical Center; or lead to other investigative and/or legal action.

Signed _____ Date _____