**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: _______________

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**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 |
|---|---|---|---|
| | | | |

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**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 |
|---|---|---|---|---|---|
| | | | | | |
| 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 MISDEMEANOR?** ☐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 dated within the last year 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 dated within the last year 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 ____________________