Jackson MEMORIAL HOSPITAL Jackson Health System PUBLIC HEALTH TRUST

APPLICATION FOR GRADUATE MEDICAL EDUCATION AT THE PUBLIC HEALTH TRUST'S JACKSON MEMORIAL HOSPITAL AND RELATED FACILITIES

Date_____

Indicate the department to which you are applying _____
Circle one: PGY 1 2 3 4 5 6 7

1. PERSONAL DATA:

Name in full _____
First Middle Last

Current mailing address _____
Street City State

_____ Telephone:_____ _____ e-mail _____
Zip Code area code

Permanent address if different from current _____
Street City State Zip Code

Place of Birth _____ Date of Birth_____

Social Security Number _____ (if you do not have a Social Security number, one must be obtained before reporting for duty as resident.)

Are you a U.S. citizen? Yes/No If no, current status or visa _____

2. EDUCATION

Medical School _____
Name Degree

_____
Location (City and State) Date or (Date Expected)

List chronologically your activities from the time of graduation from Medical School to present. Specify type of post-graduate training, if any.

FROM	TO	ACTIVITY	PLACE	DEGREE, IF ANY

(If additional space is required, please use separate sheet of paper)

3. EXPERIENCE

Special Clinical and/or Research experience _____

_____

_____

Professional practice, location and dates _____

_____

Memberships in professional societies and list any publications _____

_____

(Use separate sheet of paper if needed)

4. MEDICAL LICENSURE AND CERTIFICATION (if applicable)

Date and Results of National Boards Examinations or F.L.E.X. (please include copy of results)

_____

Attach copies of all State Licenses issued to you.

Have you ever had an application for medical licensure denied? _____. If so, state the date, circumstances, and State where your application was denied.

_____

_____

_____

Have you ever had a medical license revoked? _____. If so, state date, circumstances and State where the license was revoked. _____

_____

_____

Since your sixteenth birthday, have you ever been convicted of a felonious offense or are there felony charges currently pending against you? _____

If so, indicate as to the court involved, nature of offense, disposition or current status of the case and date of case.

_____

_____

_____

5. FOREIGN MEDICAL SCHOOL GRADUATES ONLY

Citizenship and Date _____ (if not U.S. Citizen,

type of Visa) _____. If on a J.1 exchange

visitors visa, give country _____. Have you passed your Foreign Medical

Graduates Examination in the Medical Sciences (FMGEMS)? _____

Score on Basic Sciences _____ Clinical Sciences _____ English _____ Pass/Fail (Circle one).

Give number and indicate type of certificate _____ Standard _____ Interim_____

6. **A minimum of three letters of Reference is required: (One should be from the Dean of your medical School; and two from physicians who have observed you or supervised you in recent training programs. If you have had previous post-graduate training, one letter must be from your former program director).**

   List below the names of your three references and ask them to correspond directly to the Chief of Program Director of the respective department in which you desire to residency. Each Chief and Program Director is located at Jackson Memorial Medical Center, 1611 N.W. 12th Avenue, Miami, Florida 33136.

   1. _____
      Name Address
   2. _____
      Name Address
   3. _____
      Name Address

   Any Others:

   _____
   Name Address

   _____
   Name Address

7. **PLANS AFTER PGY-1**
   What are your immediate and long range plans after PGY-1 (i.e. Military Service, residency, specialty, practice, academic medicine, etc.) Please indicate if you desire a one-year appointment only.

   _____

   _____

   _____

   _____

8. **AGREEMENT**
   If I am offered an appointment by the Public Health Trust to serve at the University of Miami/Jackson Memorial Hospital Medical Center and I accept same, I will abide by all the Rules and Regulations of the included Hospitals for members of the House Staff including but not limited to Medical Staff Bylaws, Medical Staff Rules and Regulations , Public Health Trust Policies and Procedures and the Collective Bargaining Agreement between the Public Health Trust and the Committee of Interns and Residents and will to the best of my ability fulfill the obligations of my assignment for the full term of my appointment.

   Anticipated Start Date_____ Anticipated Ending Date_____

9. **ENCLOSE WITH THE COMPLETED APPLICATION THE FOLLOWING:**

   a) Transcript of Medical School Scholastic Record
   b) Copy of State Licenses
   c) Flex or National Boards results
   d) Valid ECFMG Certificate, or ECFMG documentation

10. **"I hereby declare that I have examined this application; and to the best of my knowledge and belief, it is true, correct, and complete."**

Signature _____
Applicant

Notary Public _____

My Commission Expires _____ 20___

Seal

NOTE: A three hundred word typed or handwritten biographical sketch and a personal interview may be required by some departments.

Mail entire contents to the Chief or Program Director at

_____
_____
_____
_____
_____
_____