Application for Graduate Medical Education at the

Medical College of Georgia

Application should be returned to the training program director.

Print or Type Application

Application Data

Date 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)

____ Categorical ☐ 4th year (PGY-4) ☐ 5th year (PGY-5)

____ Preliminary ☐ 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: The H-1B visa is not accepted for Graduate Medical Education programs at the Medical College of Georgia at Augusta University

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.

5th Pathway Applicants Only:

If you participated in a 5th Pathway Program in the United States, the following documents must be attached to this application:
A copy of your 5th Pathway Certificate and proof of having passed the FMGEMS, Parts I and II of the National Board examination or the United States Licensing Exam (USMLE).

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 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 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:

Academic Honors/Publications/Professional Organizations

List any academic honors, publications or memberships in scientific/professional organizations (provide additional sheets or curriculum vitae, if necessary):

Examinations

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

❑ USMLE Step 1 Date taken _____ Score _____

❑ USMLE Step 2 Date taken _____ Score _____

❑ USMLE 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.

❑ 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, health status 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 Chief of the Service 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
Date _____

Advanced Cardiac Life Support Training ❑ Yes ❑ No
Date _____

Other: _____ 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 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 without notice. 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 GRU

_____
Applicant's Signature Date

Department Use Only

Complete the following prior to submitting application to the Housestaff Office:

APPROVED FOR APPOINTMENT ❑ Yes ❑ No

CONTRACT PERIOD From: _____ To: _____

BEGINNING PGY LEVEL _____

_____
Program Director's Signature Date

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