

## Application Form

This worksheet may be printed and used to begin completing your application off-line. **All required fields are highlighted in red and marked with an asterisk.** Please note, that some of these fields are required only in certain circumstances.

### Personal Information

#### Contact Information

First Name*	Preferred Phone*
Middle Name	Mobile Phone
Last Name*	Alternate Phone
Previous Last Name	Email*
Suffix	Last 4 digits of SSN
Preferred Name	

#### Address

##### Current Mailing Address

Address 1\*

Address 2

Country\*

State *(Required for U.S. & Canadian addresses)*

City\*

Postal Code

Is your permanent address the same as your current mailing address?\*  Yes  No

##### Permanent Address

Address 1

Address 2

Country

State

City

Postal Code

Phone

## Citizenship Information

Are you a U.S. citizen?\*  Yes  No

If yes, are you a citizen of a country in addition to the United States?  Yes  No

If yes, select your country of dual citizenship (other than the United States):

If you are not a U.S. citizen, select citizenship status:

If you are a Foreign National currently in in the U.S. with Valid Visa Status, select your current Visa/Employment Authorization Status:

F-1 - Academic Student (Employment Authorization Document - Optional Practical Training)  
F-2 - Spouse or Child of F-1  
H-1 - Temporary Worker  
H-1B - Special occupation, DoD worker, etcetera  
H-2B - Temporary worker - skilled and unskilled  
H-4 - spouse or Child of H-1, H-2, H-3  
J-1 - Visa for exchange visitor  
J-2 -Spouse or Child of J-1 Employment Authorization Document (EAD)  
O-1 - Person of Extraordinary Ability in science, arts, education, business or athletics  
TN - NAFTA Trade for Canadians and Mexicans  
E-2 - Treaty Investor, Spouse and Child (EAD)  
Diplomatic Service  
Employment Authorization Document (EAD)  
L-2 - Dependent of Intra-Company Transferee (EAD)

If you are a Foreign national, outside the U.S. or currently in the U.S. , with a valid visa status, please respond: Will you need visa sponsorship through the ECFMG (J-1) or the teaching hospital (H-1B) in order to participate in U.S. residency and/or fellowship training ?  Yes  No

If yes, please select the visa(s) you would like to apply for. Select all that apply. The system will list your Expected Visa/Employment Authorization based on your selections.  H-1B  J-1

Eligibility for ECFMG J-1 visa sponsorship is not to be presumed. For details on ECFMG J-1 requirements and restrictions, please see refer to ECFMG/EVSP website at <http://www.ecfm.org/evsp/requirements.html>

If no, Expected Visa/Employment Authorization Status (the visa status you expect to secure with Employment Authorization to participate in a program):

F-1 - Academic Student (Employment Authorization Document - Optional Practical Training)  
F-2 - Spouse or Child of F-1  
H-1 - Temporary Worker  
H-1B - Special occupation, DoD worker, etcetera  
H-2B - Temporary worker - skilled and unskilled  
H-4 - spouse or Child of H-1, H-2, H-3  
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Employment Authorization Document (EAD)  
L-2 - Dependent of Intra-Company Transferee (EAD)

If applicable, please indicate your state or province of residence in the United States or Canada:

## Match Information

### NRMP Match

I plan to participate in the NRMP match?\*  Yes  No

If yes, NRMP ID

Participating as a couple in NRMP:  Yes  No

If yes, Partner's Name:

Specialties Partner is applying to:

### NMS Match

I plan to participate in the NMS match?\*  Yes  No

If yes, AOA Match Number (NMS Number):

Participating as a couple in the NMS:  Yes  No

If yes, Partner's Name:

Specialties Partner is applying to:

### Urology Match

AUA Member Number:

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## Additional Information

USMLE/ECFMG ID:

NBOME ID:

*(Required for D.O. applicants)*

AOA Member Number:

I am ACLS (Advanced Cardiovascular Life Support) certified in the U.S.A.:  Yes  No

If yes, ACLS Expiration Date:

I am PALS (Pediatric Advanced Life Support) certified in the U.S.A.:  Yes  No

If yes, PALS Expiration Date:

I am BLS (Basic Life Support) certified in the U.S.A.:  Yes  No

If yes, BLS Expiration Date:

Sigma Sigma Phi Status:

*(D.O. applicants only)*

Alpha Omega Alpha Status:

Gold Humanism Honor Society Status:

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## Biographic Information

### General

Gender\*

Birth Place

Birth Date\*

## Self Identification

If you reside in the European Union, do not answer this question. Please ignore this section.

This section allows you to indicate how you self-identify. When selecting "Other" as a sub-category, the text field is limited to 120 characters but is not required field. If you prefer not to self-identify, please ignore this section.

How do you self-identify? Please select all that apply.

Hispanic, Latino or of Spanish origin

Colombian

Argentinean

Cuban

Dominican

Mexican/Chicano

Peruvian

Puerto Rican

Other Hispanic:

American Indian or Alaskan Native

Tribal affiliation:

Asian

Bangladeshi

Cambodian

Chinese

Filipino

Indian

Indonesian

Japanese

Korean

Laotian

Pakistani

Taiwanese

Vietnamese

Other Asian:

Black or African American

African American

Afro-Caribbean

African

Other Black:

Native Hawaiian or Pacific Islander

Guamanian

Native Hawaiian

Samoan

Other Pacific Islander:

White

Other:

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I prefer not to respond

## Language Fluency

What languages do you speak? Select all that apply. For each language that you select, including English, you will be asked to rate your proficiency in that language using the guidelines provided below.\*

**Native/Functionally Native:** I converse easily and accurately in all types of situations. Native speakers, including highly educated, may think that I am a native speaker, too.

**Advanced:** I speak very accurately, and I understand other speakers very accurately. Native speakers have no problem understanding me, but they probably perceive that I am not a native speaker.

**Good:** I speak well enough to participate in most conversations. Native speakers notice some errors in my speech or my understanding, but my errors rarely cause misunderstanding. I have some difficulty communicating necessary health concepts.

**Fair:** I speak and understand well enough to have extended conversations about current events, work, family, or personal life. Native speakers notice many errors in my speech or my understanding. I have difficulty communicating about healthcare concepts.

**Basic:** I speak the language imperfectly and only to a limited degree and in limited situations. I have difficulty in or understanding extended conversations. I am unable to understand or communicate most healthcare concepts.

- |   |   |   |                                     |
|---|---|---|-------------------------------------|
| <input type="checkbox"/> Albanian               | <input type="checkbox"/> French           | <input type="checkbox"/> Mande                  | <input type="checkbox"/> Swahili    |
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> French Creole    | <input type="checkbox"/> Marathi                | <input type="checkbox"/> Swedish    |
| <input type="checkbox"/> Amharic                | <input type="checkbox"/> German           | <input type="checkbox"/> Mon-Khmer, Cambodian   | <input type="checkbox"/> Syriac     |
| <input type="checkbox"/> Arabic                 | <input type="checkbox"/> Greek            | <input type="checkbox"/> Navajo                 | <input type="checkbox"/> Tagalog    |
| <input type="checkbox"/> Armenian               | <input type="checkbox"/> Gujarati         | <input type="checkbox"/> Nepali                 | <input type="checkbox"/> Tamil      |
| <input type="checkbox"/> Bantu                  | <input type="checkbox"/> Hebrew           | <input type="checkbox"/> Norwegian              | <input type="checkbox"/> Telugu     |
| <input type="checkbox"/> Bengali                | <input type="checkbox"/> Hindi            | <input type="checkbox"/> Patois                 | <input type="checkbox"/> Thai       |
| <input type="checkbox"/> Bulgarian              | <input type="checkbox"/> Hmong            | <input type="checkbox"/> Pennsylvania Dutch     | <input type="checkbox"/> Tongan     |
| <input type="checkbox"/> Burmese                | <input type="checkbox"/> Hungarian        | <input type="checkbox"/> Persian                | <input type="checkbox"/> Turkish    |
| <input type="checkbox"/> Cajun                  | <input type="checkbox"/> Ilocano          | <input type="checkbox"/> Polish                 | <input type="checkbox"/> Ukrainian  |
| <input type="checkbox"/> Chinese                | <input type="checkbox"/> Indonesian       | <input type="checkbox"/> Portuguese             | <input type="checkbox"/> Urdu       |
| <input type="checkbox"/> Croatian               | <input type="checkbox"/> Italian          | <input type="checkbox"/> Punjabi                | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Cushite                | <input type="checkbox"/> Japanese         | <input type="checkbox"/> Romanian               | <input type="checkbox"/> Yiddish    |
| <input type="checkbox"/> Czech                  | <input type="checkbox"/> Kannada          | <input type="checkbox"/> Russian                |                                     |
| <input type="checkbox"/> Danish                 | <input type="checkbox"/> Korean           | <input type="checkbox"/> Samoan                 |                                     |
| <input type="checkbox"/> Dutch                  | <input type="checkbox"/> Kru, Ibo, Yoruba | <input type="checkbox"/> Serbian                |                                     |
| <input type="checkbox"/> English                | <input type="checkbox"/> Laotian          | <input type="checkbox"/> Serbocroatian          |                                     |
| <input type="checkbox"/> Finnish                | <input type="checkbox"/> Lithuanian       | <input type="checkbox"/> Slovak                 |                                     |
| <input type="checkbox"/> Formosan               | <input type="checkbox"/> Malayalam        | <input type="checkbox"/> Spanish/Spanish Creole |                                     |

## Military Information

Are you committed to fulfill a U.S. military active duty service obligations/deferments?\*  Yes  No

If yes, number of years remaining

Branch

Do you have any other service obligations? (e.g. - Military Reserves, Public Health/State programs, etc.)\*  Yes  No

If yes, describe  
255 Character Max

## Additional Information

Hobbies &  
Interests  
510 Character Max

## Education

### Higher Education

This section allows multiple entries for each Undergraduate and Graduate School you have attached.

Since most non-U.S. educational systems do not follow the U.S. model, almost all students and graduates of international medical schools will indicate "None".

None

#### Entry 1

Institution\*

Location\*

Education Type\*

Field of Study\*

Degree expected or earned\*

Dates of Attendance: From Month\*

From Year\*

To Month\*

To Year\*

#### Entry 2

Institution\*

Location\*

Education Type\*

Field of Study\*

Degree expected or earned\*

Dates of Attendance: From Month\*

From Year\*

To Month\*

To Year\*

## Medical Education

This section allows entries for each Medical School you have attended.

### Entry 1

Country\*

Institution\*

Degree\*

Degree Month\*  Degree Year\*

Dates of Education\*

From Month\*  From Year\*  To Month\*  To Year\*

### Entry 2

Country\*

Institution\*

Degree\*

Degree Month\*  Degree Year\*

Dates of Education

From Month\*  From Year\*  To Month\*  To Year\*

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## Additional Information

Membership in  
Honorary/  
Professional  
Societies  
255 Characters Max

Medical School  
Awards  
510 Characters Max

Other Awards/  
Accomplishments  
510 Characters Max

# Experience

## Training

Please add any current or prior D.O. Internship, D.O. Residency, M.D. Residency or M.D. Fellowship in which you have trained, regardless of length of time spent in the training.

None

### Entry 1

Type of Training\*

Specialty\*

Institution/Program\*

Country\*

State/Province\*

City\*

Program Director\*

Supervisor\*

Chief Resident

Dates of Residency/Fellowship

From Month\*  From Year\*  To Month\*  To Year\*

Reason for Leaving   
510 Characters Max

### Entry 2

Type of Training\*

Specialty\*

Institution/Program\*

Country\*

State/Province

City\*

Program Director\*

Supervisor\*

Chief Resident

Dates of Residency/Fellowship

From Month\*  From Year\*  To Month\*  To Year\*

Reason for Leaving   
510 Characters Max



## Experience

Please add your additional experience. Clinical and Teaching experience should be treated as Work experiences. Include all unpaid extra-curricular activities and committees you have served on as a Volunteer experiences.

None

### Entry 1

Experience Type\*

Organization\*

Position\*

Supervisor

Country\*

State/Province\*

City\*

Average Hours/Week

Description  
1020 Characters Max

Reason for Leaving  
510 Characters Max

Dates of Experience

From Month\*  From Year\*  To Month\*  To Year\*

### Entry 2

Experience Type\*

Organization\*

Position\*

Supervisor

Country\*

State/Province

City\*

Average Hours/Week

Description  
1020 Characters Max

Reason for Leaving  
510 Characters Max

Dates of Experience

From Month\*  From Year\*  To Month\*  To Year\*

## Additional Questions

Was your medical education/training extended or interrupted?\*  Yes  No

If yes, please  
provide details.  
510 Characters Max

## Licensure

Please add an entry for any of your state medical licenses.

None

### Entry 1

State\*

License Type\*

License Number\*

Expiration Month\*

Expiration Year\*

### Entry 2

State\*

License Type\*

License Number\*

Expiration Month\*

Expiration Year\*

## Additional Information

Has your medical license ever been suspended/revoked/voluntarily terminated?\*  Yes  No

If yes, please  
explain:

Have you been named in a malpractice case?\*  Yes  No

If yes, please  
explain:

Is there anything in your past history that would limit your ability to be licensed or would limit your ability to receive hospital privileges?\*  Yes  No

If yes, please  
explain:

Have you ever been convicted of a misdemeanor in the United States?\*  Yes  No

If yes, please  
explain:

Have you ever been convicted of a felony in the United States?\*  Yes  No

If yes, please explain:

Are you able to carry out the responsibilities of a resident or a 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 with or without reasonable accommodations?\*  Yes  No  No Response

If no, please provide additional information:

Are you Board Certified?\*  Yes  No

If yes, Board Name

DEA Registration Number

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## Publications

Add an entry for each of your publications.

### Peer Reviewed Journal Articles/Abstracts

Journal Article(s)/Abstract(s) Title\*

255 Characters Max

Author(s)\*

*(Last Name, First Initial, Middle Initial)*

Publication Name\*

Publication Med-Line Unique Identifier (PMID)

Publication Volume\*

Issue Number\*

Pages\*

*(eg. 200-212)*

Month\*

Year\*

### Peer Reviewed Journal Articles/Abstracts (Other than Published)

Journal Article(s)/Abstract(s) Title:\*

255 Characters Max

Author(s)\*

*(Last Name First Initial Middle Initial)*

Publication Name\*

Publication Status\*

Month\*

Year\*

## Peer Reviewed Book Chapter

Chapter Title\*

225 Characters Max

Name of Book\*

Author(s)\*

*(Last Name, First Initial, Middle Initial)*

Editor(s)\*

*(First Initial, Middle Initial, Last Name)*

Publisher\*

Pages\*

*(eg. 200-212)*

Country\*

State/Province

City\*

Year\*

## Scientific Monograph

Monograph Title\*

255 Characters Max

Publication Name\*

Volume\*

Issue Number\*

*(eg. 200-212)*

Author(s)\*

*(Last Name, First Initial, Middle Initial)*

Editor(s)\*

*(First Initial, Middle Initial, Last Name)*

Publisher\*

Year\*

## Other Articles

Title of Other Article\*

255 Characters Max

Author(s)\*

Publication Name\*

Publication Date\*

*(MM/DD/YYYY)*

**Poster Presentation**

Poster Presentation Title\*   
255 Characters Max

Author(s)/Presenter(s)\*  (Last Name, First Initial, Middle Initial)

Event/Meeting\*

Country\*

State/Province

City\*

Month\*  Year\*

**Oral Presentation**

Oral Presentation Title\*   
255 Characters Max

Author(s)/Presenter(s)\*  (Last Name, First Initial, Middle Initial)

Event/Meeting\*

Country\*

State/Province

City\*

Month\*  Year\*

**Peer Reviewed Online Publication**

Online Publication Type\*   
255 Characters Max

Author(s)\*  (Last Name, First Initial, Middle Initial)

URL\*

Publication Date\*  (MM/DD/YYYY)

**Non Peer Reviewed Online Publication**

Online Publication Title\*   
255 Characters Max

Author(s)\*  (Last Name, First Initial, Middle Initial)

URL\*

Publication Date\*  (MM/DD/YYYY)

I certify that the information contained within my 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 the USF GME office; or if employed, may constitute cause for termination from the program. In addition, I consent to the transfer of my personal data to the USF Morsani College of Medicine GME office in the United States.