

Name: _____

(Last)

(First)

(Middle)

Social Security Number: _____ Email: _____

Address: _____

Telephone Numbers: Home: _____ Cell: _____

Undergraduate Education

(List every post-secondary college in which you were ever enrolled.)

Undergraduate College(s) and Location	Date(s) Attended		Degree
	From (Mo/Yr)	To (Mo/Yr)	

Medical Education

(List every medical school in which you were ever enrolled, including International Didactic Training.)

Medical School(s) and Location	Date(s) Attended		Degree
	From (Mo/Yr)	To (Mo/Yr)	

Graduate Education/Residency Training

(List all prior graduate education or residency training in which you were ever enrolled.)

School(s)/Hospital(s) and Location	Date(s) Attended		Type of Training	PGY
	From (Mo/Yr)	To (Mo/Yr)		

1. Residency/Fellowship Programs: *(Please check one):*

- | | | | |
|--|--|--|--|
| <input type="radio"/> Anesthesiology | <input type="radio"/> Emergency Medical Services | <input type="radio"/> Micrographic Surgery | <input type="radio"/> Psychiatry |
| <input type="radio"/> Cardiology | <input type="radio"/> Endocrinology | <input type="radio"/> Nephrology | <input type="radio"/> Pulmonary Crit.Care Med. |
| <input type="radio"/> Cardiology-Interventional | <input type="radio"/> Gastroenterology | <input type="radio"/> Neurology | <input type="radio"/> Pulmonology- Interventional |
| <input type="radio"/> Cardiology-Electrophysiology | <input type="radio"/> Gynecology/Oncology | <input type="radio"/> Obstetrics/Gynecology | <input type="radio"/> Rheumatology |
| <input type="radio"/> Critical Care Medicine | <input type="radio"/> Hospice & Palliative Medicine | <input type="radio"/> Orthopaedic Surgery | <input type="radio"/> Surgery- Categorical |
| <input type="radio"/> Dermatology | <input type="radio"/> Hematology/Oncology | <input type="radio"/> Pain Medicine | <input type="radio"/> Surgical Critical Care |
| <input type="radio"/> Diagnostic Radiology | <input type="radio"/> Infectious Diseases | <input type="radio"/> Pediatrics | <input type="radio"/> Urology |
| <input type="radio"/> Emergency Medicine | <input type="radio"/> Internal Medicine -Categorical | <input type="radio"/> Plastic Surgery | <input type="radio"/> Urogynecology |
| | <input type="radio"/> Internal Medicine -Preliminary | <input type="radio"/> Podiatric Medicine/Surgery | <input type="radio"/> Vascular Surgery (Residency) |

2. Level of Training Requested:

- PGY-1
 PGY-2
 PGY-3
 PGY-4
 PGY-5
 PGY-6
 PGY-7

3. Application for Training: (PGY-1) June _____ (PGY-2 and above) July _____

(year)

(year)

4. Examination Scores: *(Must provide documentation.)*

USMLE: Step I: _____ Step II (CK): _____ Step II (CS): _____ Step III: _____

COMLEX: Step I: _____ Step II (CE): _____ Step II (PE): _____ Step III: _____

NBPME: Step I: _____ Step II (CE): _____ Step II (CS): _____ Step III: _____

5. Licensure: _____
State Number Type Expiration Date

6. ECFMG: *(Must provide a copy of ECFMG certificate.)*

7. Visa Information: *(H1-B not accepted)* J-1 or EAD: _____ Expiration Date: _____ (Copy Required)

8. Citizenship: *(Must provide a copy of passport)*

9. Please Answer the Following Questions:

- A.** Have you ever been denied a license to practice medicine or eligibility to sit for a licensing exam in this state or any other state? Yes No
- B.** Have you ever been denied eligibility to participate in a graduate medical education program in this state or any other state? Yes No
- C.** Have you ever been asked to resign, or have you ever been discharged/terminated from a graduate medical education program? Yes No
- D.** Have you ever been convicted of a crime, offense, or misdemeanor in this state or any other state? Yes No
- E.** Are you now, or have you ever been the subject of a criminal proceeding in this state or any other state? Yes No
- F.** Have you ever had your privilege to participate in any state or federal medical assistance program (i.e. Medicare, Medicaid) curtailed or limited by any regulatory authority? Yes No
- G.** Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain. Yes No

(If you answered yes to any of the above questions, please attach a written detailed explanation.)

10. Attach Two Passport Size Photographs

11. Letters of Recommendation: Three letters of recommendation are required. PGY-1 must include one letter from the Dean and two others. PGY-2 and higher must provide a letter from the program director and two others. Contact your program coordinator for any additional required documents.

12. Transcripts/Diplomas: Original transcripts verifying medical school education must be submitted with the official seal. Residency training certificate/medical school diploma must also be submitted with a notarized seal.

13. Curriculum Vitae: Submit a CV to include a list of all activities chronologically, with the month and year of the start of medical education to the present. Include all periods of unemployment and/or gaps in training.

14. I understand that the information on this application is subject to verification by Cooper University Hospital. I hereby authorize Cooper to do so and I further authorize all institutions, individuals, hospitals, or organizations to release any information requested. I hereby release from liability and damages those institutions, individuals, hospitals, and organizations who provide such information. I certify that all information provided herein is true and correct. Falsification, misrepresentation, or omissions from this application will be cause for immediate termination.

Signature of Applicant: _____ Date: _____

Return completed application, education documents, and letters of recommendation to:

Program Director; Department in which residency is requested · Cooper University Hospital · One Cooper Plaza · Camden, NJ · 08103-1489

