Cooper University Hospital

Application for Graduate Medical Education

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 *From (Mo/Yr)* *To (Mo/Yr)*	Degree

Medical Education

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

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

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 *From (Mo/Yr)* *To (Mo/Yr)*	Type of Training	PGY

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

- ○ Anesthesiology
- ○ Cardiothoracic Anesthesiology
- ○ Cardiology
- ○ Cardiology-Interventional
- ○ Cardiology-Electrophysiology
- ○ Critical Care Medicine
- ○ Child Abuse Pediatrics
- ○ Dermatology
- ○ Diagnostic Radiology
- ○ Emergency Medicine
- ○ Emergency Medical Services
- ○ Emergency Ultrasound
- ○ Endocrinology
- ○ Gastroenterology
- ○ Gynecology/Oncology
- ○ Hospice & Palliative Medicine
- ○ Hematology/Oncology
- ○ Infectious Diseases
- ○ Internal Medicine-Categorical
- ○ Internal Medicine-Preliminary
- ○ Micro Surgery/Derm Oncology
- ○ Nephrology
- ○ Neurology
- ○ Obstetrics/Gynecology
- ○ Orthopaedic Surgery
- ○ Otolaryngology (ENT)
- ○ Orthopaedic Trauma
- ○ Pain Medicine
- ○ Pediatrics
- ○ Plastic Surgery
- ○ Podiatric Medicine/Surgery
- ○ Psychiatry
- ○ Pulmonary Crit.Care Med.
- ○ Pulmonology-Interventional
- ○ Rheumatology
- ○ Surgery-Categorical
- ○ Surgical Critical Care
- ○ Urology
- ○ Urogynecology
- ○ Vascular Surgery (Residency)
- ○ Women's Imaging

2. Level of Training Requested:

○ PGY-1 ○ PGY-2 ○ PGY-3 ○ PGY-4 ○ PGY-5 ○ PGY-6 ○ PGY-7 ○ PGY-8

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

4. Examination Scores: *(Must provide copy of official results.)*

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 or birth certificate.)*

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. Must Provide One Passport Photo

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: Must provide official medical school transcript conferring date degree awarded and notarized copy of medical school diploma. Copy of Certificate of completion for all residency programs

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 greater than 30 days.

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 Coordinator; Department in which residency is requested.

Cooper University Health Care

Cooper Medical School of Rowan University

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