University of Massachusetts Medical School
Office of Graduate Medical Education
55 Lake Avenue North
Worcester, Massachusetts 01655
Telephone: 508.856.2903 Fax: 508.856.6420

Application for Appointment in a Residency or Fellowship Training Program

Program In: _____ PGY Level: _____

Training to Begin: _____ Number of Years of Training Sought: _____

Personal Information

Full Name: _____
Last *First* *M.I.*

Social Security Number: _____ Date of Birth: _____

Present Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Cell Phone: _____ Email Address: _____

Education

List all schools and inclusive dates attended.

	School Name and Location		Major Field	Degree	Dates
Undergraduate:					
Graduate:					
Medical School:					

Residency Training

Hospital Name and Location		Program	Dates

Please indicate other professional activities (practice, research, military, training, etc.) since graduation from medical school:

Activity	Location	Dates

Current Licensure & Examinations

State	Type (Unrestricted or Training)	Number	Date Issued	Date Expired

United States Medical Licensing Examination (USMLE)_____OR COMLEX_____(for D.O.)

	Date Taken	Score		Date Taken	Score
Step 1			Level 1		
Step 2 CK			Level 2 CE		
Step 2 CS			Level 2 PE		
Step 3			Level 3		

American Specialty Boards

Eligible in: _____

Certified in: _____

Date: _____

ECFMG & VISA Status

ECFMG STATUS

ECFMG Number: _____

Date Issued: _____

VISA STATUS – If you are not a citizen of the U.S., please provide the following information:

Current Non-Immigrant (Temporary) Visa Type: _____ Sponsor: _____

Or

Current Immigrant (Permanent) Status: _____

Requested Visa or Immigration Status at the time of Appointment: _____

National Match Program/Interview

Have you signed an agreement with the National Resident Matching Program? _____ Number: _____

When are you available for an interview? _____

Additional Information

ADDITIONAL INFORMATION: (Please list honors, research projects, special interests, publications, teaching appointments and relevant work experiences; or attach a copy of your curriculum vitae or resume and a personal statement.):

TRAINING PLANS (What type and how many years of training do you anticipate):

CAREER GOALS (What are your career plans and preferences):

References

List three faculty members of your medical school or attending physicians who are familiar with your clinical performance and request that letters of reference be sent directly to the UMMC Program Director.

	First – Last Name & Title		Address
1.			
2.			
3.			

Date of Application:_____

SIGNATURE:_____

Please return application to the Director of the UMMS Program to which you are applying, and request the Dean of your medical school to submit to the UMMS Program Director appropriate medical school credentials and Dean's Letters.

RECENT PHOTOGRAPH
(Optional)
3" x 3"

PLEASE NOTE: The University of Massachusetts Medical Center is an Affirmative Action/Equal Opportunity Employer and is committed to increasing minority representation among its Residents and Fellows. If you wish to do so, please list your minority status:_____