



Application for Non-Matching Program Residency and Fellowship Positions

Boston Medical Center developed this application in order to ensure uniformity in the information submitted by applicants for residency and fellowship positions that are not part of a matching program. The application is adapted from material contained in the 2007 ERAS Application Worksheet, the Universal Application for Residency developed by AAMC and distributed by the National Residency Matching Program in 1997 and the Initial Limited License Application Form provided by the Commonwealth of Massachusetts Board of Registration in Medicine.

Position beginning on _____

Name of Program _____

Personal Information:

First Name: _____ Middle Name: _____ Last Name: _____
Suffix: _____ Previous Last Name: _____
Contact Email: _____
SSN: _____ Canadian SIN: _____
Birthplace: _____ Birth Date: _____

Gender: o Female
 o Male
 o No Response

Present Mailing Address:

Street Address: _____
City: _____ Country: _____
Zip Code: _____ State/Province: _____
Preferred Phone: _____ Alternate Phone: _____
Pager: _____ Mobile: _____
Fax: _____

Permanent Mailing Address:

Street Address: _____
City: _____
State/Province: _____
Zip Code: _____
Country: _____
Phone: _____

Alpha Omega Alpha Status, if applicable:

- Member of AOA
- AOA elections held in Senior Year
- No AOA Chapter at my School

Sigma Sigma Phi Status, if applicable:

- Member of SSP
- SSP elections held in Senior Year
- No SSP Chapter at my School

Citizenship:

- US Citizen
- Foreign National
- Permanent Resident
- Conditional Permanent Resident
- Refugee/asylum/displaced

Current and Expected Visa Types: (for Foreign Nationals only - check all that apply)

- B-1 - Temporary visitor for business
- B-2 - Temporary visitor for pleasure
- F-1 - Academic student business, or athletics
- F-2 - Spouse or child of F-1
- H-1 - Temporary worker
- H-1B - Specialty occupation, DoD worker, etc.
- 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
- O-1 - Extraordinary ability in sciences, arts, education, business, or athletics
- TN - NAFTA trade visa for Canadians and Mexicans
- TN - NAFTA trade visa for Canadians and Mexicans
- Diplomatic Service
- Immigrant
- EAD-Employment Authorization
- Other

International Medical Graduates:

Are you certified by the Educational Commission for Foreign Medical Graduates?

- No
- Yes

Month: _____ Year: _____

USMLE/ECFMG ID: _____

NBOME ID: _____

- I am ACLS (Advanced Cardiac Life Support) certified in the U.S.A. Expiration Date: _____
- I am PALS (Pediatric Advanced Life Support) certified in the U.S.A. Expiration Date: _____

Are you committed to fulfill U.S. Military active duty service obligations/deferments?

- Yes
- No

If Yes:

Years: _____ Branch: _____

Do you have any other service obligations? (i.e. Military Reserves or Public Health/State programs)

- Yes
- No

Description (up to 255 characters) _____

Undergraduate Education

For each undergraduate institution you have attended, please provide the requested information. This worksheet has space for you to make 2 entries. Attach additional worksheets as needed.

#1 Institution: _____ Location: _____ Major: _____ Degree: _____ Date Degree Received: Month: _____ Year: _____ Dates of Attendance: From: Month: _____ Year: _____ To: Month: _____ Year: _____

#2 Institution: _____ Location: _____ Major: _____ Degree: _____ Date Degree Received: Month: _____ Year: _____ Dates of Attendance: From: Month: _____ Year: _____ To: Month: _____ Year: _____

Graduate Education – non-medical

For each non-medical graduate educational institution you have attended, please provide the requested information. This worksheet has space for you to make 2 entries. Attach additional worksheets as needed.

#1 Institution: _____ Location: _____ Degree: _____ Date Degree Received: Month: _____ Year: _____ Dates of Attendance: From: Month: _____ Year: _____ To: Month: _____ Year: _____

#2 Institution: _____ Location: _____ Degree: _____ Date Degree Received: Month: _____ Year: _____ Dates of Attendance: From: Month: _____ Year: _____ To: Month: _____ Year: _____

Medical Education

For each medical school you have attended, please provide the requested information. This worksheet has space for you to make 2 entries. Attach additional worksheets as needed.

#1
Country: _____
Institution: _____
Degree expected or earned: o Yes o No
Degree: _____
Degree Month: _____ Degree Year: _____
Dates of Attendance:
From: Month: _____ Year: _____
To: Month: _____ Year: _____

#2
Country: _____
Institution: _____
Degree expected or earned: o Yes o No
Degree: _____
Degree Month: _____ Degree Year: _____
Dates of Attendance:
From: Month: _____ Year: _____
To: Month: _____ Year: _____

Previous Training

Have you ever been enrolled in a residency program(s) where you were required to repeat a year of training? If yes, please explain.

Have you ever failed to complete or been terminated by a postgraduate training program? If yes, please explain.

For each internship, residency, or fellowship position you have held or currently are in, regardless of the amount of time spent there, please provide the requested information. This worksheet has space for you to make 2 entries. Attach additional worksheets as needed.

#1

Specialty: _____
Type of Training: Internship Residency Fellowship
Institution/Program: _____
Country: _____ State/Province: _____
City: _____
Years: _____
Program Director: _____
Supervisor: _____
Dates of Residency/Fellowship:
From: Month: _____ Year: _____
To: Month: _____ Year: _____
Reason for leaving

#2
Specialty: _____
Type of Training: Internship Residency Fellowship
Institution/Program: _____
Country: _____ State/Province: _____
City: _____
Years: _____
Program Director: _____
Supervisor: _____
Dates of Residency/Fellowship:
From: Month: _____ Year: _____
To: Month: _____ Year: _____
Reason for leaving

Experience(s)

For each relevant work, research, volunteer or observer experience/position you have had, please provide the requested information. Include Clinical and Teaching experience as work experiences, and include all unpaid extra-curricular activities and committees you have served on as volunteer experiences. This worksheet has space for you to make 2 entries. Attach additional worksheets as needed.

#1

Type: Work Research Volunteer Observer
Organization: _____
Position: _____
Supervisor: _____
Average Hours Per Week: _____
Description _____

Reason for leaving

Dates of Experience:
From: Month: _____ Year: _____
To: Month: _____ Year: _____

#2
Type: Work Research Volunteer Observer
Organization: _____
Position: _____
Supervisor: _____
Average Hours Per Week: _____
Description _____

Reason for leaving

Dates of Experience:
From: Month: _____ Year: _____
To: Month: _____ Year: _____

Personal Statement

Please complete a personal statement if required by the program to which you are applying.

Publications

(Use also for Poster Sessions/Abstracts/Invited National or Regional Presentations)
For each publication/presentation you have had, please provide the requested information. This worksheet has space for you to make 2 entries. Attach additional worksheets as needed.

#1
Title: _____
Authors/Presenters: _____
Publication/Organization: _____
Month: _____ Year: _____
Volume: _____
Pages: _____

#2

Title: _____

Authors/Presenters: _____

Publication/Organization: _____

Month: _____ Year: _____

Volume: _____

Pages: _____

Examinations

For each examination you have taken, please provide the requested information. This worksheet has space for you to make 2 entries. Online, you can create as many entries as needed. (Osteopathic applicants: include the exams (COMLEX or USMLE) that lead to the medical licensure route you intend to pursue).

#1

Exam: _____ (ex. USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)

Status: Passed on
 Failed on
 Awaiting results from
 Will take on

Incomplete

Month: _____ Year: _____

#2

Exam: _____ (ex. USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)

Status: Passed on
 Failed on
 Awaiting results from
 Will take on

Incomplete

Month: _____ Year: _____

Medical Licensure

Has your Medical License ever been suspended/revoked/voluntarily terminated or denied?

Yes Reason _____

No _____

Have you ever been named in a malpractice case?

Yes Reason _____

No _____

Is there anything in your past history that would limit your ability to be licensed or to receive hospital privileges?

Yes Reason _____

No _____

Have you ever been convicted of a felony?

Yes Reason _____

No _____

Are you Board Certified?

Yes Board Name _____

No

DEA Registration Number _____ if applicable

Expiration Month _____ Expiration Year: _____

State Licenses

For each state license you have, please provide the requested information. This worksheet has space for you to make 2 entries. You can create as many entries as needed online.

#1

State _____

License Type Full Temporary or Limited Inactive

License Number _____

Expiration Month _____ Expiration Year _____

(License number, expiration month, and expiration year is only required if license type is "Full")

#2

State _____

License Type Full Temporary or Limited Inactive

License Number _____

Expiration Month _____ Expiration Year _____

(License number, expiration month and expiration year is only required if license type is "Full")

Race

This page allows entries for race self-identification. You may select one or more races. You are not required to identify your race. If you choose not to, please select "No Answer." Attach additional worksheets as needed.

No Answer

White

Black

American Indian or Alaskan Native

Please specify the name of enrolled or principal tribe: _____

o Asian:

- o Asian Indian
- o Pakistani
- o Chinese
- o Filipino
- o Japanese
- o Korean
- o Vietnamese
- o Other: _____

o Native Hawaiian or Other Pacific Islander:

- o Native Hawaiian
- o Guamanian or Chamorro
- o Samoan
- o Other Pacific Islander: _____

o Other: _____

Ethnicity

This page allows entries for ethnicity. You are not required to identify your ethnicity. If you choose not to, please select "No Answer." You may indicate whether you're Spanish/Hispanic/Latino/Latina or not. If you indicate Spanish/Hispanic/Latino/Latina, you may make one or more selections from the list below. If your selection does not appear, enter your own selection where it states "Specify Other."

o No Answer

o Not Spanish/Hispanic/Latino/Latina

o Spanish/Hispanic/Latino/Latina

Select all that apply:

- o Mexican, Mexican American, Chicano/Chicana
- o Puerto Rican
- o Cuban
- o Other

Specify Other: _____

References

Letters of reference have been requested from the following individuals:

Name and Title:
 Institution
 Address

Telephone Number

Name and Title:
 Institution

Address
Telephone Number

Name and Title:
Institution
Address
Telephone Number

Curriculum Vitae

Please attach a current curriculum vitae. Be sure to explain any gaps in your CV.

Miscellaneous

Are you able to carry out the responsibilities of a resident in the specialties and at the specific training programs to which you are applying including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements with or without reasonable accommodations?
 Yes Limiting Aspects _____
 No _____
 No Response _____

Was your medical education/training extended or interrupted?
 Yes Reason _____
 No _____
 No Response _____

Hobbies and Interests:

Medical School Awards:

Other Awards/Accomplishments:

Membership in Honorary/Professional Societies:

I certify that the information contained within this 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, or if employed, may constitute cause for termination from the program.

Signature

Date

Name of Applicant – Type or Print