

APPLICATION FOR POST GRADUATE TRAINING

(PLEASE TYPE OR PRINT)

NAME: _____

DATE: _____ AOA #: _____

S.S.# _____ DATE OF BIRTH: _____

RESIDENCY SPECIALTY: Emergency Medicine EM/IM ENT Family Medicine

General Surgery Internal Medicine Neurology Neuro Surgery OB/GYN Ophthalmology Orthopedics

Pediatrics Podiatry Traditional Intern Urology Fellowship _____ Other _____

Residency Location Preference Macomb Center Oakland Center Providence

Current Training Level: OGME 1 (TRK/TRAD) OGME 2 OGME 3 OGME 4 OGME 5

TRAINING DATES REQUESTED: FROM: _____ TO: _____

APPLICATION INSTRUCTIONS AND REQUIREMENTS

1. Application may be submitted anytime before December 1, of the year prior to desired contract year. Interns should submit application AFTER beginning their internship.
2. It is your responsibility to:
 - A. Obtain 3 letters of reference, including your Dean's letter.
 - B. Have a copy of your medical school transcripts and a copy of your National Board Scores sent to the Office of Medical Education.
 - C. Residency applicants must send a copy of your Medical School Diploma and a letter of reference from your current program director.
3. A personal interview is required AFTER your application is completed. Interviews are conducted by individual departments and arranged by training director of the specialty to which you are applying.
4. A completed application consists of the following:
 - ___ Photocopy of medical school diploma
 - ___ Minimum of three (3) physician references
 - ___ Reference from DME or Dean of Medical School
 - ___ Medical School Transcripts
 - ___ National Board Scores
 - ___ Copies of current BCLS & ACLS Cards
5. If you do not hear from the specialty trainer regarding an interview date or if you have any questions regarding your application status please contact the office of medical education appropriate to the program you are seeking.
6. All interviews should be completed by December of the year prior to desired starting date.
7. Return all applications to Medical Education at your preferred location:

St John Macomb Center	St John Oakland Center	Providence
12000 E. 12 Mile Rd.	27351 Dequindre Rd	16001 W. 9 Mile Rd.
Warren, MI 48093	Madison Heights, MI 48071	Southfield, MI 48075
586 576-4140 phone	248 967-7795 phone	248 849-8441 phone
586-576-4146 fax	248-967-7794 fax	248-849-3216 fax

Education

High School and Address:

1. _____

Graduation Date:

College and Address: Degree, Master or Field:

1. _____
2. _____
3. _____
4. _____

**Attendance Dates, Graduation Date,
Degree, Master or Field:**

Osteopathic Medical School:

1. _____
2. _____

**Attendance Dates, Graduation Date:
Degree:**

Other Formal Education:

1. _____
2. _____

AOA Approved Rotating Internship: (Hospital name, address, telephone number, and dates)

1. _____
2. _____

AOA Approved Residency: (Hospital name, address, telephone number, and dates)

1. _____
2. _____

Licensed to practice in the following states:

State	License No.	Date
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Portions of the National Board of Osteopathic Medical Examination Passed:

Part I Part II Part III

Do you have any Public Health Service obligation: Yes No

Have you ever been a member of the U.S. Armed Forces? Yes No

Type and Date of Discharge: _____

Any remaining service obligation: Yes No

Honors received: Academic and others (give details and dates)

1. _____
2. _____
3. _____
4. _____

References

(If applicable, include two references from any of the participating hospital staff physicians.)

List minimum of three physicians: (Include complete address)

1. _____
Name

Street Address

City, State, Zip

3. _____
Name

Street Address

City, State, Zip

2. _____
Name

Street Address

City, State, Zip

4. _____
Name

Street Address

City, State, Zip

Permanent Home Address _____
Number Street

City State Zip Code

Phone Number: (Please Include area code) _____

Signature _____

Present Address _____
Number Street

City State Zip Code

Phone Number: (Please include area code) _____

Beeper Number: (Please include area code) _____

Email Address: _____

Research experience or interests:

Future Career Plans:

Practice Interest:

Geographic area in which you wish to practice: Rural Urban Suburban

Principal area of practice interest:

Primary Care (Office based/ambulatory) Specify Specialty _____

Other Specialty, Specify _____

Teaching

Research

Do you have BCLS Yes No If yes: _____
Expiration date

ACLS Yes No If yes: _____
Expiration date

Are you a Certified Instructor Yes No If yes: _____
Attach copies of cards Expiration date

ACTIVE BCLS AND ACLS CERTIFICATION IS A REQUIREMENT FOR INTERNSHIP

Authorization for Release of Information

To be completed by prospective resident:

By applying for appointment to St. John Health, I authorize the Participating Hospitals to consult with members of the medical staffs of other hospitals with which I have been associated and with others who may have information bearing on my competency, character, and ethical qualifications. I furthermore consent to the participating hospital's inspection of all records and documents that may be material to an evaluation of my professional qualifications, competency, and moral and ethical qualifications for this appointment. I furthermore release from any liability all representatives of the participating hospitals and their medical staffs for their acts performed in good faith and without malice in connection with evaluation my application and my credentials; and release from any liability individuals and organizations, who provide information to the participating hospitals in good faith and without malice concerning my competence, ethics, character, and other qualifications for this appointment, including otherwise privileged or confidential information. I also release from any liability, all representatives of the participating hospitals for their acts performed in good faith and without malice in providing information to other institutions where I may apply for training or privileges, concerning my competence, ethics, character and other qualifications.

All statements herein are true and I understand that any false statements made by me in this application, if discovered after employment, may result in dismissal from the program.

Signature of Applicant

Witness

Date

Date