

MEDICAL EDUCATION RESIDENT INFORMATION SHEET

Please complete the following information and fill in any blank areas:

FIRST NAME:

MIDDLE NAME:

LAST NAME:

MICHIGAN ADDRESS:

CITY:

STATE:

ZIP:

PHONE:

EMAIL:

BIRTH DATE:

BIRTH PLACE:

CITIZENSHIP:

SOCIAL SECURITY:

GENDER:

OTHER NAMES USED:

LANGUAGE FLUENCY:

MILITARY OBLIGATION:

MEDICAL SCHOOL:

GRADUATION DATE:

CERTIFICATION DATE FROM ECFMG:

MARITAL STATUS: Married Single

TYPE OF VISA: (Please check either J1 or H1) J1 H1

ECFMG # _____ ISSUE DATE: _____

STARTING DATE AT ST. JOHN HOSPITAL: _____
(If other than July 1, 2005)