

**STRONG MEMORIAL HOSPITAL
OF THE UNIVERSITY OF ROCHESTER
601 ELMWOOD AVENUE
ROCHESTER, NY 14642**

**PSYCHIATRY RESIDENCY AND
FELLOWSHIPS**



NAME (PRINT) _____

SOCIAL SECURITY # _____

PRESENT ADDRESS _____ Phone _____
Street

_____ City State Zip

PERMANENT ADDRESS _____ Phone _____
Street

_____ City State Zip

E-MAIL ADDRESS _____

DATE OF BIRTH* _____ If not a US Citizen _____

PLACE OF BIRTH* _____ Type Of Visa (Only J-1 acceptable) _____

CITIZENSHIP* _____ Immigration # _____

Foreign Medical Graduates: ECFMG # _____

NAME OF SPOUSE* _____

OR NEAREST RELATIVE _____ Relation _____

ADDRESS OF RELATIVE _____ Phone _____

Do you have a commitment for military or National Health Corps service? _____

* The New York State Human Rights law prohibits discrimination because of race, creed, color, national origin, age, sex, disability, or marital status.

EDUCATION (Please include degrees to be granted and any non-degree work)

Degree (A.B., B.S., etc.) University of College Month Year

Degree (M.D., D.O., etc.) University of College Month Year

Other Degrees University of College Month Year

HOSPITAL AND CLINICAL EXPERIENCE, IF ANY:

Position Hospital City Year

Position Hospital City Year

PROGRAM: (please check appropriate program to which you are applying. A personal interview is required. Time of the interview must be arranged in advance.)

- [] General Residency Program [] Child & Adolescent Psychiatry Residency Program [] Geriatric Psychiatry Fellowship Program [] Forensic Psychiatry Fellowship Program

POSITION DESIRED PGY-2, 3, 4, 5

Board Certification: Yes ___ No ___ Discipline: _____

Ever resigned or withdrawn association from previous residency or fellowship program to avoid the imposition of disciplinary measures? Yes ___ No ___ Reason _____

Ever disciplined by, dismissed from, or not re-appointed to a previous residency or fellowship program? Yes ___ No ___ Reason: _____

Ever had medical licensure limited, restricted, suspended, revoked, denied or subject to probationary conditions? Yes ___ No ___ Reason: _____

Any pending or previous professional misconduct proceedings or pending or previous malpractice actions, judgments or settlements? Yes ___ No ___ Reason: _____

Ever been convicted of a misdemeanor or felony in any jurisdiction? Yes ___ No ___ Reason: _____

I certify that the information contained in 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 residency/fellowship position. I further understand that upon appointment I will be required to document my citizenship and complete a health assessment that includes a physical examination and drug and alcohol testing.

Date Submitted Usual Signature (Written)

RETURN APPLICATION TO PROGRAM DIRECTOR, University of Rochester Medical Center, 300 Crittenden Boulevard, Rochester, NY 14642

THIS APPLICATION BECOMES - FOR THOSE APPOINTED - A PERMANENT RECORD