

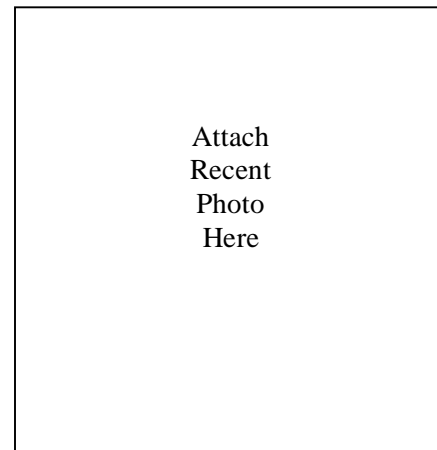
APPLICATION FOR RADIATION ONCOLOGY RESIDENCY

University of Rochester Strong Memorial Hospital
601 Elmwood Ave
Rochester NY, 14642

Position beginning in: _____

NAME: _____
(Last) (First) (Middle)

Social Security Number: _____



PRESENT ADDRESS

(Street) (City) (State) (Zip)

(____) _____
(Day phone)

(____) _____
(Evening phone)

PERMANENT ADDRESS

Name of person through whom I can always be contacted: _____

(Street) (City) (State) (Zip)

(____) _____
(Permanent phone)

EMAIL ADDRESS _____

My citizenship: ____ US ____ Other

My visa status (if applicable): ____ permanent
____ temporary (please check): ____ J-1 ____ H-1

ECFMG Registration (if applicable): _____

My spouse/partner's name: _____ Number of dependents: _____

UNDERGRADUATE EDUCATION

School: _____ City/State/Country: _____

Dates attended: _____ to _____

Degree: _____ Major: _____

School: _____ City/State/Country: _____

Dates attended: _____ to _____

Degree: _____ Major: _____

GRADUATE EDUCATION

School: _____ City/State/Country: _____

Dates attended: _____ to _____

Graduate degree: _____ Area of study: _____

School: _____ City/State/Country: _____

Dates attended: _____ to _____

Graduate degree: _____ Area of study: _____

MEDICAL EDUCATION

School: _____ City/State/Country: _____

Month/year of matriculation at medical school: _____ Month/year anticipated graduation: _____

Electives completed/planned (place a “p” after planned senior electives):

Honors/Awards:

HOSPITAL AND CLINICAL EXPERIENCE (if any):

Position	Hospital	City	Year
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Position	Hospital	City	Year
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PREVIOUS RESIDENCY/FELLOWSHIP TRAINING (if any):

Type of training ____ Residency ____ Fellowship

Program	Department
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Institution	City/State/Country
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Dates attended: From _____ to _____

Completed training: Y/N; if no, reason why: _____

Qualification(s) obtained, if any: _____ or N/A

BOARD CERTIFICATION: Yes ____ No ____

Discipline: _____

NYS Licensure/Limited Permit: Yes ____ No ____

I plan to take the examinations checked below before I begin the Radiation Oncology Residency Program for which I am now applying:

USMLE, Step I ____ USMLE, Step II ____ USMLE, Step III ____

I have already passed the following examinations (please provide dates):

NBME, Step I ____ NBME, Step II ____ NBME, Step III ____

USMLE, Step I ____ USMLE, Step II ____ USMLE, Step III ____

Flex _____
Date _____ State(s) of licensure _____

List any additional exams passed (if applicable):

INTERVIEW SCHEDULING

_____ The following general time period is most convenient for me: _____ to _____

_____ I am able to schedule an interview on the following specific dates:

_____ Date _____ Date _____ Date _____ Date

_____ I am unable to come for an interview.

SERVICE OBLIGATIONS (National Health Service Corps, Armed Forces Scholarship, State Programs, etc)

_____ I am not required to fulfill any service obligations

_____ I am committed to fulfill a service obligation: _____ beginning month/year _____ number of years committed

PERSONAL STATEMENT:

LETTERS OF REFERENCE, IN ADDITION TO THE DEAN'S LETTER, HAVE BEEN REQUESTED FROM THE FOLLOWING INDIVIDUALS:

A. Name and title: _____
Institution: _____
Address: _____

B. Name and title: _____
Institution: _____
Address: _____

C. Name and title: _____
Institution: _____
Address: _____

D. Name and title: _____
Institution: _____
Address: _____

Check one:

____ I hereby waive access to the above letters and will so inform the authors.

____ I desire access to the above letters and will so inform the authors.

Printed name of applicant

Signature of applicant

Date: _____

PLEASE ANSWER THE FOLLOWING HONESTLY (ANY "YES" ANSWER REQUIRES YOU TO STATE A REASON):

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_____

Applicant name (print) _____

Applicant Signature_____

RETURN APPLICATION TO: Wendy Malorzo, Radiation Oncology Resident Program Administrator,
601 Elmwood Ave Box 647, Rochester, NY 14642

THIS APPLICATION BECOMES - FOR THOSE APPOINTED - A PERMANENT RECORD