HOUSTON METHODIST HOSPITAL
GRADUATE MEDICAL EDUCATION TRAINING PROGRAMS
APPLICATION FOR NON-MATCH/ NON-ACGME ACCREDITIED FELLOWSHIP

I. IDENTIFYING INFORMATION				
PROGRAM APPLYING TO:		**ACADEMIC YEAR APPLYING FOR:**		
Last Name:	First Name:	Middle Name:	Suffix:	Other Name(s) used:
Date of Birth:	Place of Birth:	Citizenship:		
What type of visa will you need (if applicable)?	Languages spoken other than English:			

II. ADDRESS	
Address:	City, State, Zip
Contact Phone:	Personal Email Address: (not school or institution)

III. LICENSURE (if applicable)		
Type:	License/ Certificate Number	Expiration Date:
Texas Physician License: (attach copy)		
Texas Physician in training permit: (attach copy)		
DEA: (attach copy)		
Other State License: (attach copy)		
NPI Number:		

IV. BOARD CERTIFICATIONS			
TYPE	**BOARD NAME**	**CERTIFICATION DATE**	**EXPIRATION DATE**
☐ NEW ☐ RECERT			

V. EDUCATION	
MEDICAL SCHOOL (last to first in chronological order)	**Attach additional sheets if necessary.**
1. Name of Institution:	Dates Attended: From: (mm/yy) To: (mm/yy)
City, State	Degree:
2. Name of Institution:	Dates Attended: From: (mm/yy) To: (mm/yy)
City, State	Degree
3. Name of Institution:	Dates Attended: From: (mm/yy) To: (mm/yy)
City, State	Degree:

List in chronological order every post graduate training program you have attended. Attach additional sheets if necessary.

1. Current or Last Institution:	Dates Attended: From: (mm/yy) To: (mm/yy)
Program Name:	Type: Internship, if separate from residency Residency, Fellowship
Did you successfully complete the program?: YES ☐ NO ☐ ☐ If still in training, expected completion/graduation date. (mm/yy) (If, NO, please explain on a separate sheet and reference this section and program.	
2. Previous Institution:	Dates Attended: From: (mm/yy) To: (mm/yy)
Program Name:	Type: Internship, if separate from residency Residency, Fellowship
Did you successfully complete the program?: YES ☐ NO ☐ (If, NO, please explain on a separate sheet and reference this section and program.	
3. Previous Institution:	Dates Attended: From: (mm/yy) To: (mm/yy)
Program Name:	Type: Internship, if separate from residency Residency, Fellowship
Did you successfully complete the program?: YES ☐ NO ☐ (If, NO, please explain on a separate sheet and reference this section and program	

VI. EXAMINATIONS & ECFMG CERTIFICATION (Attach copy)

USMLE/ COMLEX	SCORE	# of Attempts	Date of each Attempt	ECFMG
Step I				Certificate Number:
Step II CK				Date Issued:
Step II CS				
Step III				

VII.A DISCIPLINARY ACTIONS (If, YES, please submit explanation on a separate sheet and reference this section.)

1.	Has your license to practice medicine in any jurisdiction ever been limited, suspended, revoked, voluntarily or involuntarily, relinquished, or are any actions pending?	☐ YES ☐ NO
2.	Have your privileges at any medical facility ever been suspended, diminished, revoked, not renewed, or are any actions pending, or are your current privileges the subject of a focused review, or any other kind of peer review, proctoring, or special supervision?	☐ YES ☐ NO
3.	Have you ever voluntarily or involuntarily resigned your privileges/membership from any medical facility or medical practice?	☐ YES ☐ NO
4.	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization, or are any actions pending?	☐ YES ☐ NO
5.	Has your Drug Enforcement Administration (DEA) registration ever been limited, revoked, or voluntarily relinquished, or are any actions pending?	☐ YES ☐ NO
6.	Has a regulatory body for medical practice sanctioned you?	☐ YES ☐ NO
7.	Have you ever been convicted or charged with a felony, or misdemeanor (other than minor traffic offenses), or are any actions pending?	☐ YES ☐ NO
8.	Have you ever been denied acceptance or membership or been deselected from an HMO, PPO, or other health care entity?	☐ YES ☐ NO
9.	Have you ever been excluded from participation in the Medicare, Medicaid, or CHAMPUS programs on the basis of fraudulent federal program billing practices?	☐ YES ☐ NO
10.	Have you ever been excluded from participation in the Medicare, Medicaid, or CHAMPUS programs on the basis of any criminal violations of federal program regulations or requirements?	☐ YES ☐ NO

VII.B MALPRACTICE

1.	Regardless of whether you have been named individually as a defendant, has a law suit(s) ever been filed or has a judgment(s)/settlement(s) ever been made in a case involving your actions or omissions as a physician or as an employee or employer, or are any such suits, judgments, or settlements pending?	☐ YES ☐ NO
2.	Has your professional liability insurance policy been cancelled or renewal refused?	☐ YES ☐ NO
3.	Have limitations ever been placed on the scope of your professional liability insurance coverage, or have you received notice of intent to limit your coverage?	☐ YES ☐ NO

IX. REFERENCES: Please provide the names and addresses of whom you have asked to write reference letters, you may include your program director(s), faculty, and peers. DO NOT LEAVE BLANK

Name:	Address or Phone number:
Name:	Address or Phone number:
Name:	Address or Phone number:

X. PROFESSIONAL EXPERIENCE

Inclusive Dates:		Institution	Position	Address
To	From			

XII. Applicant Attestation

By my signature, I declare that all information provided by me or on my behalf, within this application or in conjunction with this application, has been submitted truthfully and accurately.

I understand that it is my sole responsibility to immediately submit an update of this questionnaire to Houston Methodist Hospital GME Office in the event that any answer(s) to any of these questions become inaccurate or incomplete while my application is in process. I also understand that failure to do so may constitute cause to deny entry into an Houston Methodist Hospital program.

I hereby authorize the release to Houston Methodist Hospital all records and documents bearing on my professional competence, character, training, ethical qualifications and any other material necessary to render an evaluation of my appointment to the House Staff of Houston Methodist Hospital.

I further agree to be bound by the terms thereof in all matters relating to the consideration of my application, and I further agree to abide by such hospital and staff policies, rules and regulations as may be from time to time enacted.

Applicant's Signature:_____ **Date:**_____

Applicant's Printed Name:_____

I authorize the release of this information to all persons associated with Houston Methodist Hospital Graduate Medical Education and its training programs, as necessary, for processing of this application.

I certify that the above information is true and correct.

Signature_____ **Date (M/D/YY)**_____

PLEASE COMPLETE ALL INFORMATION ON EACH PAGE
INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

REQUIRED DOCUMENTS FOR A COMPLETE APPLICATION

The application packet must contain the following documentation:

- Houston Methodist Hospital GME Non-Match application, ERAS® or SF Match (or other match) application
- Current CV
- Personal Statement not to exceed one page in length
- Three letters of recommendation (dated within the past twelve months) to include current program director and faculty
- Copy of Medical School Diploma
- Copy of Medical School Transcript
- Copy of Certificates of any prior residencies or fellowships
- Copy of ECFMG certificate (if applicable)
- Copy of J-1 visa (if applicable)
- Copy of USMLE Steps 1, 2 and 3 test scores
- Copy of Physician license (all states) or PIT Permit (if previously a resident in Texas)
- Copy of DEA certificate (if fully licensed and have a DEA certificate)

Return the completed application and all attachments to the Program Coordinator