HOUSTON Methodist LEADING MEDICINE

# GRADUATE MEDICAL EDUCATION TRAINING PROGRAMS
# APPLICATION FOR NON-MATCH RESIDENCY/ FELLOWSHIP TRAINING/ OR TRANSFER APPLICANTS

## I. IDENTIFYING INFORMATION

| PROGRAM APPLYING FOR: | ACADEMIC YEAR APPLYING FOR: |
|---|---|
| | |

| Last Name: | First Name: | Middle Name: | Suffix: |
|---|---|---|---|
| | | | |

| Other Name(s) used during training: | Date of Birth: | Place of Birth: | Social Security Number: |
|---|---|---|---|
| | | | |

| Citizenship: | If not a U.S. citizen or U.S. permanent resident, type of visa held or will apply for: |
|---|---|
| | |
| **Visa expiration date:** | **Date of entry into the United States:** |
| | |
| **Languages spoken other than English:** | |
| | |

## II. ADDRESS

| Home Address: | Mailing Address: |
|---|---|
| | |
| **City, State, Zip:** | **City, State, Zip:** |
| | |
| **Home Phone:** | **Cell Phone:** |
| | |
| **Work Phone:** | **Email Address:** |
| | |

## III. LICENSURE (if applicable)

| Type: | Number: | Expiration Date: |
|---|---|---|
| Texas (Full Medical) License: (attach copy) | | |
| Texas Physician-in-Training Permit: (attach copy) | | |
| Personal DEA: (attach copy) | | |
| Personal DPS: (attach copy) | | |
| Other State License: (attach copy) State Name: | | |
| National Provider ID: | | |

| IV. BOARD CERTIFICATION (if applicable) | | | |
|---|---|---|---|
| **Type:** | **Board Name:** | **Certification Date:** | **Expiration Date:** |
| | | | |

**Recertification: □ YES □ NO Recertification Date: _____ New Expiration Date: _____**

| V. EDUCATION | |
|---|---|
| **MEDICAL SCHOOL (starting with most recent/last to first in chronological order)** | |
| **1. Name of Institution:** | **Dates Attended:**<br>**From: (mm/yy)** **To: (mm/yy)** |
| **Address, City, State, Zip / Country:** | **Degree:**<br>**Date Awarded:**<br>**Major:** |
| **2. Name of Institution:** | **Dates Attended:**<br>**From: (mm/yy)** **To: (mm/yy)** |
| **Address, City, State, Zip / Country:** | **Degree:**<br>**Date Awarded:**<br>**Major:** |

| VI. POST GRADUATE TRAINING | | |
|---|---|---|
| **List in chronological order starting with most recent/last to first <u>every postgraduate training program</u> you have been associated with. Attach additional sheets if necessary - reference this section number and title.** | | |
| **1. Name of Institution:** | **Dates Attended:**<br>**From: (mm/yy)** **To: (mm/yy)** | |
| **Program Name:** | **Type:**<br>**Internship ☐ Residency ☐ Fellowship ☐** | |
| **Mailing address:** | **Program Director:** | |
| **City:** | **State:** | **Zip:** |
| **Country:** | **Phone:** | **Fax:** |

**Did you successfully complete the program?:** ☐ **YES** ☐ **NO**

(If NO, please explain on a separate sheet and reference this section and Program)

| 2. Name of Institution: | Dates Attended:<br>From: (mm/yy) To: (mm/yy) |
|---|---|
| Program Name: | Type:<br>Internship ☐ Residency ☐ Fellowship ☐ |
| Mailing address: | Program Director: |

| City: | State: | Zip: |
|---|---|---|
| Country: | Phone: | Fax: |

Did you successfully complete the program?: ☐ YES ☐ NO

(If NO, please explain on a separate sheet and reference this section and Program)

| 3. Name of Institution: | Dates Attended:<br>From: (mm/yy) To: (mm/yy) |
|---|---|
| Program Name: | Type:<br>Internship ☐ Residency ☐ Fellowship ☐ |
| Mailing address: | Program Director: |

| City: | State: | Zip: |
|---|---|---|
| Country: | Phone: | Fax: |

Did you successfully complete the program?: ☐ YES ☐ NO

(If NO, please explain on a separate sheet and reference this section and Program)

**VI. EXAMINATIONS (Attach copy)**

| USMLE: | Scores: | # of Attempts: | | COMLEX: | Scores: | # of Attempts: |
|---|---|---|---|---|---|---|
| Step 1: | | | | Level 1: | | |
| Step 2 CK: | | | | Level 2 CE: | | |
| Step 2 CS: | | | | Level 2 PE: | | |
| Step 3: | | | | Level 3: | | |

**VII. ECFMG Certification (If Applicable) (Attach Copy)**

ECFMG Certificate Number: _____ Expiration Date or Other: _____

| VIII. DISCIPLINARY ACTIONS | |
|---|---|
| 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 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 either your Drug Enforcement Administration registration or DPS (State Controlled Substances) registration ever been limited, suspended, revoked, or voluntarily or involuntarily 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 civil 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 |
| **MALPRACTICE UPDATE** | |
| 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 so limit your coverage? | ☐ YES ☐ NO |

**IX. REFERENCES: Please provide at least (3) three names and address of whom you have asked to write a recommendation letter, you may include your program director(s), faculty, and peers.**

| | |
|---|---|
| Name: | Address: |
| Name: | Address: |
| Name: | Address: |
| Name: | Address: |
| Name: | Address: |
| Name: | Address: |

| X. PROFESSIONAL EXPERIENCE | | | | |
|---|---|---|---|---|
| Inclusive Dates | | Institution | Position | Address |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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## 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 The 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 the Houston Methodist Hospital program.

I hereby authorize the release to The 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 The 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 the 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/Y):** ____/____/____

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

## REQUIRED DOCUMENTS FOR A COMPLETE APPLICATION:

- ☐ **Complete application fully. Incomplete applications will not be considered**.
- ☐ Request the registrar(s) of your medical school(s) to send transcripts directly to the program coordinator.
- ☐ Three letters of recommendation to include current Program Director and faculty.
- ☐ Submit current Curriculum Vitae with your application.
- ☐ Copy of ECFMG certificate, if you are a Foreign Medical Graduate.
- ☐ Copy of Physician license (all states) or PIT (if previous residency was in Texas)
- ☐ Copy of DEA certificate (if fully licensed and have a DEA certificate)
- ☐ Copy of DPS certificate (if fully licensed in the State of Texas and have a DPS certificate)
- ☐ Submit a NOTARIZED TRUE COPY of all diplomas and certificates of completion for Medical School and any Residency and/or Fellowship program(s) you have already completed.
- ☐ Submit a current Personal Statement

## RETURN COMPLETED APPLICATION TO:

**Attn: Leah (Ginger) Jozwiak**
**Houston Methodist Hospital**
**Department of Pathology and Genomic Medicine**
**6565 Fannin, Suite B490**
**Houston, TX 77030**