SUNY / Health Science Center at Brooklyn
Affiliated Hospitals

Brookdale Hospital Medical Center
Coney Island Hospital
Veterans Affairs Medical Center at Brooklyn
Kings County Hospital Center
Kingsboro Psychiatric Hospital
Long Island College Hospital
Long Island Jewish Medical Center, New Hyde Park
Maimonidies Medical Center
St.John's Episcopal - South Shore
Saint Vincent's Medical Center of Richmond
Staten Island Hospital
University Hospital of Brooklyn

Application for Residency

Position Applied for/Program

Program Director | Service Applied To

a. ☐ Residency: in the ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th year of post medical school

b. ☐ Subspeciality, Residency or Fellowship in the ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th year of post medical school

c. ☐ Research Fellowship:(Indicate Speciality or Service)_____ ☐Full time ☐ Part time

Personal Data

Last Name	First	Middle	Social Security Number
Current Address (Street, City / State, Zip)			Phone
Local Address (Street, City / State, Zip)			
Emergency Contact Person (Name and Address)			Phone

Education

NRMP ☐Yes ☐No Number:

Undergraduate Education / College	City	State	Year Graduated	Degree (Specify)

Medical/Dental College	City	State	From/To	Graduated (MO/YR)

I ☐ Was ☐Will be granted a diploma as ☐DO ☐DDS ☐DMD ☐MD

5th Pathway ☐No ☐Yes (If Yes, Indicate name of hospital, medical school affiliation and period attended)

Foreign Medical School Graduates

ECFMG# **Issue Date:** **Expiration Date:**

One of these items must be completed by graduates of foreign medical schools, including U.S. citizens.

a. ☐ I have a standard Certificate from the Educational Council for foreign Medical Graduates and am attaching a photocopy.

b. ☐ I took the exam on (Month, Day, Year)_____, and am awaiting the results.

c. ☐ I have been notified that I may take the FMGEMS Examination on (Month, Day, Year) _____

d. ☐ I will file application with ECFMG to have my medical education credentials evaluated and to receive permission to take the examination. Indicate date in which application will be filed (Month, Day, Year)_____

e. ☐ English Proficiency Exam completed.

f. ☐Test of English as a Foreign Language(TOEFEL)

Has there ever been any action taken against you for professional misconduct or malpractice or has any disciplinary action been taken concerning your professional performance? ☐No ☐Yes.

If Yes, supply any information

Professional Experience

Professional post graduate hospital or institutional experience

Hospital or Institution	City & State	Title & PGY (Int.,Res., Year)	Speciality or Service (Mo/Day/ Fellow)	From (Mo/Day/ Fellow)	To

Please attach a Curriculum Vitae and Biography

☐ USMLE, Step I ☐ USMLE, Step II ☐ USMLE, Step III

I have already passed the examinations checked below on the dates indicated:

☐ NBME, Part II_____ (Date) ☐ NBME, Part II_____ (Date) ☐ NBME, Part III _____ (Date)

☐ USMLE, Step I_____ (Date) ☐ USMLE, Step II_____ (Date) ☐ USMLE, Step III _____ (Date)

☐ Flex:_____ (Date) _____ (State(s) of licensure)

List Any Additional Examinations Passed (FMGEMS, Day 1; Day2; VZE, Day1; VZE, Day 2 ; ECFMG Medical Science Exam):

License

National Board of Medical Examiners: **Passed** ☐ Part I ☐ Part II ☐ Part III ☐ None

FLEX PartI ☐ Part II **FMGEMS** ☐ Part I ☐ Part II

If any of the above have been completed, list the certifying No. and name of exam_____

I have a full and unrestricted licence to practice medicine in New York State or another of the U.S., territory of the U.S. and/or U.S. possession: ☐ Yes ☐ No

New York State Licence No._____Year_____

Other state, territory or possession licenced in _____License No. _____Year_____

This Application must be accompanied or followed by letters of recommendation from two physicians or dentists who have known the applicant for at least one year. Letters, preferably from the Chief of the applicant's service and the Administrator of the hospital where the applicant last served or is serving, should mention the type of position for which the candidate is making application.

Applicants who are participants in the National Resident Matching Program are required, according to the NRMP, to provide only the credential-recommendation letter from the Dean of the applicant's medical school.

I certify that all informarion provided is true and accurate. I understand that any misleading or false information may be sufficient cause for immediate dismissal in the event of my appointment to this SUNY residency program.

Signature: _____ Date: _____

State University of New York Health Science Center at Brooklyn

450 Clarkson Avenue - Box 52, Brooklyn, N.Y. 11203-2098 • Tel-718-270-1584 • Fax-718-270-3327

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St.John's Episcopal - South Shore
Saint Vincent's Medical Center of Richmond
Staten Island Hospital
University Hospital of Brooklyn

House Staff Physician Questionnaire

Personal Data

Last Name	First	Middle	Social Security Number
Department			PGYLevel
Medical Speciality		Subspeciality	

THE FOLLOWING QUESTIONS ARE FOR STATISTICALPURPOSES ONLY AND ARE IN NO WAY USED TO APPOINT OR EVALUATE

Date of Birth	☐ **Male** ☐ **Female**	Country of Birth	Country of Citizenship

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Seperated

Maiden Name or Alias

Ethnicity Code (Choose from list below):

☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ Other ☐ Native American

Citizenship

Visa Status:

☐ Permanent Resident(PR) ☐ U.S. Born(CT) ☐ Naturalized Citizen (NC) ☐ J-1 ☐ H-1B ☐ Other

Visa Number	**Expiration Date**	**Other Visa**

Local Address:

Street

City State Zip Code

Telephone

I certify that all information provided is true and accurate. I understand that any misleading or false information may be sufficient cause for immediate dismissal in the event of my appointment to this SUNYresidency program.

Signature: _____ Date: _____

Print name as it should appear on certificate of training _____

For Office Use Only

SMS#	☐ **Information In System**	**Date**	**By:**

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