

**GRADUATE MEDICAL EDUCATION  
RESIDENCY AND FELLOWSHIP  
APPLICATION**

UNIVERSITY OF ILLINOIS AT CHICAGO  
AND AFFILIATED GRADUATE MEDICAL EDUCATION PROGRAMS  
APPLICATION REQUIREMENTS

Please read the following and the attached application form carefully and provide the information and credentials requested. Only completed application files can be processed for appropriate review and subsequent recommendations.

1. All first year post medical school appointments (no prior approved graduate training) are made via the National Resident Matching Program (2450 North State NW, Suite 201, Washington, DC 20037-1141), and participation in this program by the medical student or foreign graduate is required. We accept NRMP applications but please note the additional requirements from the list below.
2. The following credentials are to be forwarded to this office as promptly as possible:
  - a. Original transcripts of medical, dental, or osteopathy school records **must be sent directly from the school** and a copy of M.D. diploma.
  - b. Foreign school graduates: copies of ECFMG certificate, medical school diploma, and license to practice medicine in home country with translations of documents if they are not in English. Transcripts of medical school must be notarized if not original. Reference letters **must be original** and sent directly from the person writing in your behalf.
  - c. Four letters of recommendation addressed to the Director of the Graduate Medical Education Programs should include one from the Dean of your School and three from faculty or staff who are familiar with your performance record. If the latter are acquainted with the Program Director, they may prefer to write directly to him.
  - d. **Important —Physician Candidates—** We require reference letters from Program Directors of all accredited U.S. residencies or fellowships in which you have served and if applicable from current or past medical employers.
  - e. Copies of USMLE scores, NBME scores, ECFMG scores, FMGEMS scores, FLEX scores.
  - f. Curriculum Vitae.
  - g. Personal Statement: This should include your professional interests, achievements, and plans for the future. Reference should be made to research experience and training, special projects or scientific work you have engaged in, and any notable professional accomplishments you have achieved. You may also wish to describe your personal interests, activities, and circumstances, including your family and household.
3. Personal interviews are very helpful, and in most programs, are essential. These are to be arranged directly with the office of the Director of the program for which you are applying. Do not call the Graduate Medical Education Office.

Please return all forms and credentials to:

Occupational Medicine Residency Program  
(M/C 684)  
University of Illinois at Chicago  
835 S. Wolcott Avenue, E-144  
Chicago, IL 60612

The University of Illinois policy is to be in full compliance with all federal and state nondiscrimination and equal opportunity laws, orders, and regulations, and it will not discriminate against any persons because of race, color, sex, religion, handicap, or national origin in any of its educational programs and activities.

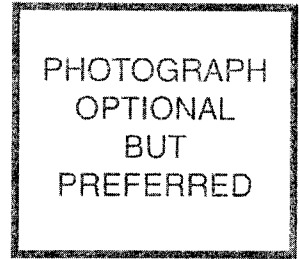


**APPLICATION**

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For office use only

UNIVERSITY OF ILLINOIS AT CHICAGO AND AFFILIATED GRADUATE MEDICAL EDUCATION PROGRAMS



I hereby apply for clinical graduate training in \_\_\_\_\_ (specialty program)

at \_\_\_\_\_ year level, to begin \_\_\_\_\_

I am participating in NRMP  Yes  No

I am participating in another matching program \_\_\_\_\_ (list)

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
(Please print) (Last) (First) (Middle)

Mailing Address \_\_\_\_\_

\_\_\_\_\_ City or Town State or Country Zip Code Phone \_\_\_\_\_

Permanent Home Address \_\_\_\_\_  
(If different from above)

\_\_\_\_\_ City or Town State or Country Zip Code Phone \_\_\_\_\_

USA Citizen  Foreign Citizen \_\_\_\_\_ (country) Permanent Immigrant Visa # \_\_\_\_\_  J Visa

Place of Birth \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

State of Health \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_

Do you have any condition that would preclude you from forming rational judgments, reacting quickly in emergent situations, or working for an extended period of time (i.e., night call) under stressful conditions without interruption? *If yes, attach a detailed explanation.*  Yes  No

Have you ever been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach statement including date and place of conviction(s) and nature of such offense(s).*  Yes  No

**RECORD OF LICENSURE**

A license to practice in Illinois, either temporary or permanent, is mandatory.

Are you licensed to practice medicine in Illinois? *If yes, submit copy of license.*  Yes  No

Date of certificate \_\_\_\_\_ Expiration date \_\_\_\_\_ License # \_\_\_\_\_

I have been licensed to practice medicine in the following states:

	State	License #	Date of Issue	Expiration Date
Original license	_____	_____	_____	_____
Other license	_____	_____	_____	_____
Other license	_____	_____	_____	_____
Other license	_____	_____	_____	_____

Have you ever been denied a license, permit, or privilege of taking an examination by any licensing authority? *If yes, attach a detailed explanation.*  Yes  No

Have you ever had a license or permit incumbered in any way (revoked, suspended, surrendered, censored, restricted, limited, placed on probation)? *If yes, attach a detailed explanation.*  Yes  No

Have you ever been named in a malpractice suit? *If yes, attach a detailed explanation.*  Yes  No

**EDUCATION:**

(a) College or University (include graduate work)

DEGREE  
and field

DATES ATTENDED  
from to

(b) Medical, Dental, or Osteopathy School

**PREREQUISITES: I have passed the following examinations: (give date and score)**

Date Month & Year	Score	Place	Date Month & Year	Score
USMLE/NBME Pt. I _____	_____	State Lic. Exam _____	_____	_____
USMLE/NBME Pt. II _____	_____	Flex _____	_____	_____
USMLE/NBME Pt. III _____	_____	VQE _____	_____	_____
ECFMG _____	_____	FMGEMS _____	_____	_____

My ECFMG # is \_\_\_\_\_

INTERNSHIP: Flexible \_\_\_\_\_ Straight \_\_\_\_\_  
 at \_\_\_\_\_ in \_\_\_\_\_  
 (Specialty) \_\_\_\_\_  
 (Location) \_\_\_\_\_

RESIDENCY or FELLOWSHIP in \_\_\_\_\_  
 at \_\_\_\_\_ in \_\_\_\_\_  
 (Institution) \_\_\_\_\_ (Specialty) \_\_\_\_\_  
 (Location) \_\_\_\_\_  
 at \_\_\_\_\_ in \_\_\_\_\_  
 (Institution) \_\_\_\_\_ (Location) \_\_\_\_\_  
 at \_\_\_\_\_ in \_\_\_\_\_  
 (Institution) \_\_\_\_\_ (Location) \_\_\_\_\_

RESEARCH, TEACHING EXPERIENCE:  
 \_\_\_\_\_ in \_\_\_\_\_  
 (Rank) \_\_\_\_\_ (Field) \_\_\_\_\_  
 at \_\_\_\_\_ in \_\_\_\_\_  
 (Institution) \_\_\_\_\_ (Location) \_\_\_\_\_

under direction of \_\_\_\_\_

Other medical experience: \_\_\_\_\_

Scholarships, prizes, or awards \_\_\_\_\_

Membership in professional and/or honorary societies \_\_\_\_\_

Publications: (Please submit a list, or copy of each, if available)

REFERENCES: List below the names and positions of those you have requested to write in your behalf.  
 We require original letters—We do not accept Xerox copies.

Medical Students: We require Dean's letter as well as letters from three faculty or staff who are familiar with your performance record.

Physician Candidates: In addition to the Dean's letter or equivalent, we require letters from all program directors or any accredited U.S. residencies or fellowships in which you have served and from current or past medical employers.

Name \_\_\_\_\_ Position \_\_\_\_\_  
 Name \_\_\_\_\_ Position \_\_\_\_\_  
 Name \_\_\_\_\_ Position \_\_\_\_\_  
 Name \_\_\_\_\_ Position \_\_\_\_\_

(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.

I HAVE READ AND I UNDERSTAND THE INSTRUCTIONS FOR THE COMPLETION OF THIS APPLICATION. I CERTIFY THAT THE INFORMATION SUBMITTED ON THESE APPLICATION MATERIALS IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE; I UNDERSTAND THAT ANY FALSE OR MISSING INFORMATION MAY DISQUALIFY ME FOR THIS POSITION OR BE GROUNDS FOR TERMINATION IN CASE OF EMPLOYMENT.  
 SIGNATURE OF APPLICANT: \_\_\_\_\_ DATE: \_\_\_\_\_  
 NOTE: THE SIGNATURE AND DATE ON EACH APPLICATION MUST BE ORIGINAL.