Application for Residency Training

Instructions: Return this application to the Program Director of the clinical program to which you are applying, School of Medicine, University of Louisville, Louisville, Kentucky 40292. Request the Office of your Dean to submit a letter of recommendation and your medical school credentials directly to the Program Director. A personal statement, transcript, and a curriculum vitae which details your activities since completion of high school should also be included with this application. (The University of Louisville Hospitals participate in the National Resident Matching Program and the applicant should adhere to the published schedule of dates.)
Date: ___________________________ NRMP (or other Match) Number: ___________________________

Name: ___________________________ Social Security Number: ___________________________

Present Address: ____________________ Telephone: ( )____________________

Permanent Address: __________________ Telephone: ( )____________________

Birthplace: ___________________________ Date of Birth: ____________________________ Sex ___________________________

Marital Status: □ M □ S Name of Spouse: ___________________________ No. of Dependents: ___________________________

Citizen of U.S.? ___________________________ Nationality: ___________________________

Military Service: (Branch, Dates Served, and Rank)

_________________________________________________________________________________________

_________________________________________________________________________________________

High School: ___________________________ City: ___________________________ Dates: ___________________________

Pre-Medical Education

University: ___________________________ Dates: ___________________________

Address: ___________________________ Degree: ___________________________

University: ___________________________ Dates: ___________________________

Address: ___________________________ Degree: ___________________________

Medical Education

Medical School: ___________________________ Dates: ___________________________

Address: ___________________________ Degree: ___________________________

Medical School: ___________________________ Dates: ___________________________

Address: ___________________________ Degree: ___________________________

Post-Graduate Education

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<thead>
<tr>
<th>Institution</th>
<th>Address</th>
<th>Type of Specialty</th>
<th>Dates</th>
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<tbody>
<tr>
<td>PGY-1</td>
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<td>PGY-2</td>
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<td>PGY-3</td>
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<td>PGY-4</td>
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<td>PGY-5</td>
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<td>Other</td>
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<td>Other</td>
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Fellowships or Research Work

_________________________________________________________________________________________

(List additional fellowships, research work and publications on back sheet)
<table>
<thead>
<tr>
<th>Medical License: Yes</th>
<th>No</th>
<th>State:</th>
<th>Number:</th>
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**Post Graduate Exam Status:** Date Candidacy or Certificate No.

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<th>USMLE I</th>
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<td>USMLE II</td>
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<td>USMLE III</td>
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Appointment Desired: PG Level Program

Desired Date Appointment to Begin:

**International Medical Graduates Must Complete the Following:**

<table>
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<th>E.C.F.M.G. Certificate No.</th>
<th>Date</th>
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<tr>
<th>Visa: Type</th>
<th>Number</th>
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Port and Date of Entry:

Date(s) Available for Interview:

Interests in fields other than Medicine:

Names and Addresses of Three Individuals **Whom You Have Requested** to Write Supportive Recommendations:

________________________
________________________
________________________

Below, state briefly your plans for post-graduate training and future practice.

________________________
________________________
________________________

PHOTOGRAPH

I certify that all information in this application is true and no material omissions have been made.

Signature: ______________________ Date: ______________________