HENRY FORD HEALTH SYSTEM

Graduate Medical Education Application

Instructions: Please print or type and answer all applicable questions on both sides of the application.

Name: ______________________________

Daytime Phone: ______________ SSN: ____/____/____ Date of Birth: ____/____/____

Present Address: ______________________________

Street | Apt # | Telephone #

____

City | State/Country | Zip

Permanent Address: ______________________________

Street | Apt # | Telephone #

____

City | State/Country | Zip

U.S. Citizen: ☐ Yes ☐ No If no, visa status ______________________________

When do you wish to begin your training? month: ______________ year: ______________

EDUCATION: List all undergraduate, graduate and medical school educations, in chronological order.

Institution	Location/State	Date of Training	Degree & Date

MEDICAL TRAINING: List all previous post graduate training/experience, in chronological order.

Institution	Location/State	Date of Training	Degree & Date

OTHER EXPERIENCE: If your training has not been continuous since graduation from medical school, please provide an explanation.

____

HOW DID YOU HEAR ABOUT US?

____

____

PLEASE COMPLETE THE REVERSE SIDE

EXAMINATIONS:

		Date Taken	Score(s)
USMLE	Part I		
	Part II		
	Part III		
COMLEX	Part I		
	Part II		
	Part III		
ECFMG Sponsorship Number			
ECFMG Certification Number			

LICENSING INFORMATION:

Do you have a current medical license? ☐ No ☐ Yes State(s): ____________

Do you have a current controlled substance license? ☐ No ☐ Yes # : ____________

CRIMINAL BACKGROUND CHECK

Have you ever been convicted of a felony? ☐ No ☐ Yes If yes, explain:

REFERENCES: Please contact each individual listed below and ask them to forward a reference directly to the department chairman of the program you are applying to.

	Name/Title	Address
1.		
2.		
3.		

Please check the program(s) you are applying to:

Fellowship Program

- ☐ Ophthalmology
- ☐ Hospice and Palliative Medicine
- ☐ Surgery
- ☐ Colon/Rectal
- ☐ Transplant
- ☐ Trauma
- ☐ Vascular
- ☐ Urology
- ☐ Other
- ☐ Physics

I certify that the information I have provided on this application is accurate.

Signature ____________ Date of application ____________

Please return the completed application to: