

Return with supporting documents to:  
**CLEVELAND CLINIC FLORIDA**  
**GRADUATE MEDICAL EDUCATION**  
2950 Cleveland Clinic Boulevard  
Weston, Florida 33331  
Phone: 954/659-6211  
Fax: 954/659-6216  
Toll Free Number: 1-866-293-7866 ext. 56211

**APPLICATION FOR CLINICAL RESIDENCY  or FELLOWSHIP**   
Please Print or Type

APPLICATION FOR RESIDENCY/FELLOWSHIP IN \_\_\_\_\_

TO BEGIN ON \_\_\_\_\_ AT GRADUATE LEVEL \_\_\_\_\_

Match Number (if applicable) \_\_\_\_\_ Medical School NRMP Code \_\_\_\_\_

**PERSONAL DATA**

\_\_\_\_\_  
Last Name First Name Middle Name Social Security Number

\_\_\_\_\_  
Present Mailing Address (Street, City, State, Country, Postal Code) Area Code/Home Phone Number

\_\_\_\_\_  
Permanent Mailing Address (Street, City, State, Country, Postal Code)

\_\_\_\_\_  
Area Code/Work Phone Number Area Code/Fax Number e-mail address Date of Birth

**EDUCATION - Name and Location of School - Dates of Attendance and Degree Obtained**

\_\_\_\_\_  
College or University Address Dates Attended Degree

\_\_\_\_\_  
Advanced Degree School Address Dates Attended Degree

\_\_\_\_\_  
Medical School Address Dates Attended Degree

United States Medical Licensing Examination: \_\_\_\_\_  
Step I Step II Step III

**HOSPITAL EXPERIENCE (Please list all previous training. Use additional sheet if necessary)**

\_\_\_\_\_  
GL-1 year Address Dates Attended Type

\_\_\_\_\_  
Residency-Hospital Address Dates Attended Specialty

\_\_\_\_\_  
Residency-Hospital Address Dates Attended Specialty

**ADDITIONAL INFORMATION:**

Are you aware of any limitation that would prevent you from performing the duties of the training position for which you are applying?  No

Yes Explain: \_\_\_\_\_

**Military Status (U.S.A.) present status and service record:**

Do you have a military or USPHS commitment?  No  Yes

If yes: Starting \_\_\_\_\_ for \_\_\_\_\_ years in \_\_\_\_\_ (Branch of service)

Do you hold a Reserve commission?  No  Yes Branch \_\_\_\_\_ Rank \_\_\_\_\_

Are you required to attend reserve meetings?  No  Yes Summer training camp? \_\_\_\_\_

**Do you have a Florida Medical License? If yes, please submit a copy of your medical license.**

No  Yes Number: \_\_\_\_\_ Permanent: \_\_\_\_\_ Training Certificate: \_\_\_\_\_

List states where you hold permanent licensure - include number and expiration date:

\_\_\_\_\_

Have you ever been denied a medical license or had a license revoked?  No  Yes

If yes, explain: \_\_\_\_\_

**Do you have a Drug Enforcement Administration (DEA) registration in Florida? If yes, please submit a copy of your DEA certificate.**

No  Yes DEA Number: \_\_\_\_\_

**International Medical Graduates Only:**

**Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?**  No  Yes

Certificate number: \_\_\_\_\_ Certification valid through date: \_\_\_\_\_

**Examination Taken and Test Scores**

VQE 1 \_\_\_\_\_ 2 \_\_\_\_\_

NBME 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

FMGEMS 1 \_\_\_\_\_ 2 \_\_\_\_\_

USMLE: 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

Are you a citizen of the United States?  Yes  No Permanent resident?  Yes  No A# \_\_\_\_\_

If not, are you currently in the U.S.? If so, what is your status?

J-1 Visa  Research  Clinical How long? \_\_\_\_\_

H1B Visa  Research  Clinical How long? \_\_\_\_\_

Other \_\_\_\_\_  Exp. Date \_\_\_\_\_

IF not in the U.S., what type of Visa may we advise you about:  J-1  H-1B

**References and Supporting Documents:**

**PGY1:** Please submit a personal statement and ask at least two physicians who have supervised you in a clinical setting to send letters in support of your application. Please ask your dean to send a letter of commendation, including a transcript. Also, a statement of your class standing, if available.

**PGYII and above:** Please submit a personal statement and three letters of recommendation two of which must be from physicians who have supervised you in a clinical setting to send in support of your application. Your completed application will include this application form, curriculum vitae, and a copy of letter of commendation from medical school dean, medical school diploma, and certificate (or other validation) of all previous training.

**Fellowship and Registered International Medical Graduates:** In addition to the above requirements, send a **certified copy** of your ECFMG certificate and qualifying exam results.

**DO NOT SEND ORIGINAL DOCUMENTS. NO DOCUMENTS OR REPRINTS WILL BE RETURNED.**

*The policy of Cleveland Clinic Florida is to provide equal opportunity to all of our employees and applicants for employment. Decisions concerning employment, transfers and promotions are all made upon the basis of the best qualified candidate without regard to color, race, religion, national origin, age, sex, handicapped status, ancestry or status as a disabled or Vietnam era veteran*

**I certify that the information given on this form and attached is true, accurate and complete.**

Date \_\_\_\_\_

Signature of Applicant

**FOR CLEVELAND CLINIC FLORIDA USE ONLY:**

**Approved by:**

Department Program Director or Supervising Physician

Chairman, Graduate Medical Education Committee