ROWAN UNIVERSITY
School of Osteopathic Medicine

Graduate Medical Education
Phone: (856) 566-7121
Fax: (856) 566-6222

One Medical Center Dr.
Academic Center Suite 162
Stratford, NJ 08084-1501

Dear Doctor:

Attached is an application for residency and fellowship programs. This application is used for the Residency and Fellowship Programs at RowanSOM / Jefferson Health New Jersey / Virtua Our Lady of Lourdes Medical Center.

Please check with the program for deadline dates and available positions. To be considered for a residency or fellowship program, please send the following to the Program Director's office as soon as possible:

1. Completed application (typed or printed legibly in black ink)
2. Official medical school transcript
3. COMLEX Part I, II, and III Board scores
4. Three (3) current letters of recommendation
5. Copy of contract from all prior GME training
6. Copy of internship and/or residency certificates
7. Copy of any state license (if applicable)
8. Copy of the CDS and DEA certifications (if applicable)
9. Copy of Milestone report from your program
10. MSPE

Should you have any questions, please call the Graduate Medical Education Office at 856-566-7121.

Sincerely,

Joanne Kaiser-Smith, D.O., FACOI, FACP
Associate Dean, Graduate Medical Education

Chuck Tucker, M.A.
Director, Graduate Medical Education

P.S. Visit us on the web at http://www.rowan.edu/som/education/graduate_medical/index.html

APPLICATION FOR RESIDENCY/FELLOWSHIP TRAINING

RowanSOM / Jefferson Health New Jersey / Virtua Our Lady of Lourdes Medical Center

Application for Residency/Fellowship in _____

For Post Graduate Year (i.e., PGY 2, 3) _____ beginning July, _____

PLEASE TYPE OR PRINT CLEARLY IN BLACK INK.

Name _____
(Last) (First) (Middle)

Social Security No. _____ - _____ - _____ DOB _____ AOA No. _____

Present Address _____ Phone (_____)_____

_____ Zip _____

Permanent Address _____ Phone (_____)_____

_____ Zip _____

Check preferred mailing address as listed above: _____ Present Address _____ Permanent Address

Phone where you can be reached during the day: (_____) _____

E-Mail _____

Emergency Contact _____

Address _____

Phone: Day (_____)_____ Night (_____)_____

Are you a: _____ U.S. Citizen? _____ Permanent Resident? _____ Other?*
*If other, please provide documentation for eligibility to be employed in the U.S.

References: List the names, titles and addresses of three references.

1. _____

_____

2. _____

_____

3. _____

_____

PRE-PROFESSIONAL EDUCATION: List, in order, Colleges or Universities you have attended.

Name of College	Location	Dates of Attendance	Degree and Date

PROFESSIONAL EDUCATION: List medical school(s) you attended.

Name of Medical School	Location	Dates of Attendance	Degree and Date

POST-GRADUATE EDUCATION:

Internship: _____Dates _____/_____/_____ to _____/_____/_____

Institution _____ City / State _____

Residency: Specialty _____Dates_____/_____/_____to _____/_____/_____

Institution _____ City / State _____

Hospital Affiliations: List Hospital names, locations and dates of Hospital staff appointments.

_____

_____

Present Membership in Organizations: List professional, scientific, etc.

_____

_____

Research or Practical Experience: Include Publications, if any.

_____

_____

National Board of Osteopathic Medical Examiners board scores (COMLEX):

Part I _____ Date of Examination _____

Part II - CE _____ Date of Examination _____

Part II - PE _____ Date of Examination _____

Part III _____ Date of Examination _____

New Jersey License Number *(if applicable)* _____

Please attach copy of New Jersey license.

Has your New Jersey license ever been suspended or revoked?

Yes _____ No _____

If yes, please explain: _____

New Jersey CDS Number *(if applicable)* _____

Has your New Jersey CDS certificate ever been suspended or revoked?

Yes _____ No _____

If yes, please explain: _____

Federal DEA Registration Number *(if applicable)* _____

Has your Federal DEA certificate ever been suspended or revoked?

Yes _____ No _____

If yes, please explain:_____

Do you have a license to practice medicine in any other state(s)?

Yes _____ No _____

If yes, list states, dates and license numbers.

State	Dates	License Number

Have you ever been involved in a malpractice suit?

Yes _____ No _____

If yes, please give the date and nature of case(s) and status of the suit, i.e., open, dismissed, closed with payment.

Date	Nature of Case

Discuss your plans after you finish your residency/fellowship program. Include practice location, if known.

Please use the space below to amplify upon your biographic data with any information that you think would be helpful in the evaluation of your application.

The Associate Dean for Graduate Medical Education is the only authorized person who can offer letters of acceptance or contracts to any of our residency or fellowship programs. Any other offer letters or contracts will not be recognized by the Rowan University School of Osteopathic Medicine or any of its affiliated programs or hospitals.

Your signature below indicates that you have completed this application in good faith and all answers are complete and honest. You also understand that no one other than Associate Dean for Graduate Medical Education at RowanSOM is authorized to make offers of acceptance or issue contracts to our programs.

_____ _____

(Applicant's Signature) (Date)

_____

(Print Name)

Rowan does not discriminate in admissions or access to its programs and activities on the basis of race/color, national origin, ethnicity, religion/creed, disability, age, marital status, sex, sexual orientation or veteran's status.

Appointment to this position requires that you are not listed by the Office of Inspector General (OIG) and/or the General Services Administration (GSA) as excluded from participating in federal health care, research, or other grant programs.

RowanSOM / Jefferson Health New Jersey / Virtua Our Lady of Lourdes Medical Center

AUTHORIZATION FOR RELEASE OF INFORMATION AND RELEASE FROM CIVIL LIABILITY

I specifically authorize the University and its authorized representatives to consult with the management and members of the medical staffs of other hospitals, health care facilities, previous colleges/universities and/or other institutions with which I have been associated and with others who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter. This University or its authorized representatives may inquire and inspect all records and documents that may be material to the above.

I hereby release from civil liability any individual or institution reviewing or providing information relative to my application for residency/fellowship at RowanSOM /Jefferson Health New Jersey / Virtua Our Lady of Lourdes Medical Center.

_____ _____

(Applicant's Signature) (Date)

_____

(Print Name)