ONMM Application for Resident

Applicant Name		
Last name	*First*	*Middle*
Residency Type:		
Training period for which applying:	*Start date*	*Finish date*

Application Packet Required Check-list
✓ **Completed Standardized Residency Application Form with Signature**
✓ **Official Medical School Transcript**
✓ **Three (3) Letters of Recommendation *(must be current)***
✓ **Copy of Contract from most current GME training**
✓ **Copy of Internship and/or Residency certificates**
✓ **Copy of State Licensures *(if applicable)***
✓ **Copy of any CDS and DEA certifications *(if applicable)***
✓ **Copy of most recent Milestones report(s) from all current/prior GME program(s)**
✓ **MSPE**
✓ **Updated Curriculum Vitae (CV)**
✓ **Provide COMLEX Part I, II and III Board scores**

Personal Data			
Other names used:			
Present Address			
Street	*City*	*State*	*ZIP / Postal code*
Permanent Address			
Street	*City*	*State*	*ZIP / Postal code*
Telephone			
Home	*Work*	*Mobile*	*Fax*
E-mail:			
Citizenship			
Country of citizenship	*Visa status*		

Education				
(Mo/Yr) – *(Mo/Yr)*		*(Undergraduate School)*	*(Major)*	*(Degree)*
(Mo/Yr) – *(Mo/Yr)*		*(Graduate School, if applicable)*	*(Major)*	*(Degree)*
(Mo/Yr) – *(Mo/Yr)*		*(Medical School)*	*(Country)*	*(Degree)*
(Mo/Yr) – *(Mo/Yr)*		*(Residency)*		*(AP, CP, AP/CP, other)*
(Mo/Yr) – *(Mo/Yr)*		*(Other GME, if applicable)*		*Area of training*
(Mo/Yr) – *(Mo/Yr)*		*(Other GME, if applicable)*		*Area of training*

Hospital Affiliations		
List Hospital date, name and location of Hospital Staff appointments.		
Dates	**Hospital Name**	**Location**
(Mo/Yr) – *(Mo/Yr)*		
(Mo/Yr) – *(Mo/Yr)*		
(Mo/Yr) – *(Mo/Yr)*		

Present Membership and Leadership/Research Experience	
List professional, scientific, etc.	
Date	**Organization**
(Mo/Yr) – *(Mo/Yr)*	
(Mo/Yr) – *(Mo/Yr)*	
(Mo/Yr) – *(Mo/Yr)*	

Publications and Presentations	
List any publications or presentation	
Date	**Publication or Presentation**
(Mo/Yr) – *(Mo/Yr)*	
(Mo/Yr) – *(Mo/Yr)*	
(Mo/Yr) – *(Mo/Yr)*	

Other Experience

In chronological order, list other educational experiences, jobs, military service or training that is not accounted for above.

(Mo/Yr) – *(Mo/Yr)*	
(Mo/Yr) – *(Mo/Yr)*	
(Mo/Yr) – *(Mo/Yr)*	

National Boards

Please indicate national board examination dates and results received.

USMLE Step 1		**USMLE Step 2**		**USMLE Step 3**	
Date passed	*Score (optional)*	***CK** - Date passed*	*Score (optional)*	*Date passed*	*Score (optional)*

ECFMG Certificate Number (if applicable)	*Date ECFMG Certificate Granted (if applicable)* (MM-YYYY)

COMLEX Level 1		**COMLEX Level 2**				**COMLEX Level 3**	
Date passed	*Score (optional)*	***CE** - Date passed*	*Score (optional)*	***PE** - Date passed*	*Score (optional)*	*Date passed*	*Score (optional)*

Medical Licensure

Please list any states in which you hold a license to practice medicine. Please provide a license number. If an application is pending in a state, please write "pending."

(State)	*(Date Issued)*	*(Medical License Number)*	*(Active?)* ☐ Yes ☐ No
(State #2)	*(Date Issued)*	*(Medical License Number)*	*(Active?)* ☐ Yes ☐ No

Have you ever been reprimanded, or had your license suspended or revoked in any of these states?	**Yes** ☐ (If so, please attach an explanation and indicate if it is resolved.) **No** ☐
Have you ever been reprimanded, or had your DEA certificate suspended or revoked in any of these states?	**Yes** ☐ (If so, please attach an explanation and indicate if it is resolved.) **No** ☐
Have you ever been named in (and/or had a judgment against you) in a medical malpractice legal suit?	**Yes** ☐ (If so, please attach an explanation and indicate if it is resolved.) **No** ☐

Board Certification

Please indicate any areas of board certification, if applicable. If not, leave blank.

Board	*Area of Certification*	*Date of Certification*

Letters of Recommendation and/or References

Please list the individuals who will write your letters of recommendation. At least three are required.

Reference #1

Name	*Title*		
Institution			
Address	*City*	*State*	*ZIP / Postal Code*
Telephone	*Email*		

Reference #2

Name	*Title*		
Institution			
Address	*City*	*State*	*ZIP / Postal Code*
Telephone	*Email*		

Reference #3

Name	*Title*		
Institution			
Address	*City*	*State*	*ZIP / Postal Code*
Telephone	*Email*		

Reference #4 (optional)

Name	*Title*		
Institution			
Address	*City*	*State*	*ZIP / Postal Code*
Telephone	*Email*		

Signature *(may omit if submitting electronically)*

I hereby certify that all of the information on this application is accurate, complete, and current to the best of my knowledge, and that this application is being made for serious consideration for Residency indicated in the application. I understand that accepting more than one Residency position constitutes a violation of professional ethics and may result in the forfeiture any Residency position offered.

Signature	*Date*

Please use the area below to amplify upon your biographic data with any information that you think would be helpful in the evaluation of your application and your future plans after residency/Residency. Please include location, if known.

Disclosure: Offer letters will come directly from the program coordinator or director after review and approval from Virtua's GME office. Virtua 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 status, per the Non-Discrimination and Accessibility Requirements – ACA Section 1557 Policy (provided upon request).

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.

Conditions of Application, Release and Immunity

In return for my application being considered by the above Institution, I agree to be legally bound to the following terms and conditions:

1. The information given in or attached to this application is accurate and complete to the best of my knowledge and fairly represents the current level of my education, training, capability and competence to exercise the Residency requested. I agree to provide complete and accurate information regarding all questions on the application form. I also agree to provide such additional information as may be requested by the program to which I am applying. Failure to produce this information or additional information will prevent my application from being evaluated and acted upon. I am willing to make myself available for interviews concerning this application.

2. I have had an opportunity to review the GME Eligibility, Recruitment, Selection and Appointment policy along with any other applicable program policies and sample contract for the program to which I am applying. I specifically agree to abide by them if my application is approved and agree that the terms, conditions and procedures outlined in those documents pertaining to my application, this will be binding whether or not my application is approved.

3. To the fullest extent permitted by law, I extend immunity to, release from any and all liability and agree not to sue:
    a. Virtua Health, Inc. or Rowan University;
    b. any authorized representative of Virtua Health, Inc. or Rowan University; and
    c. any person providing information to or receiving information from any of the Virtua Health, Inc. or Rowan University, for any actions or communications relating to my application or any other professional review activity.

4. The term “professional review activity’ means any action or communication by any of the Institution or persons referenced above related to any:
    a. determination as to whether I may have a contract with said Institution;
    b. review, recommendation or evaluation related to such status or otherwise related to my clinical competence or professional conduct.

5. I authorize Virtua Health and persons on their behalf to share information with each other and consult with third parties regarding my clinical competence, professional conduct, character, ethics, behavior, or other matters bearing on my qualifications or my ability to perform the functions of the position(s) for which I am applying. This includes the right to obtain all documents, recommendations, reports, statements or other information relating to such matters, and I hereby consent to the release of such information.

I acknowledge I have read and agree to the aforementioned above.

By signing below, I certify that I have read and fully understand the above.

Signature: _____ Date: _____

Print Name: _____