



Good Health. Generation to Generation.

Application for Residency/Fellowship Training

Instructions: Please type or print. Submit the following documents in addition to this form:

- Curriculum vitae
- Copy of Medical School Diploma
- Copy of COMLEX scores
- Copy of internship certificate
- Three letters of recommendation, including letter from DME or program director for your internship and prior residency program, if applicable

Last Name _____ **First Name** _____ **M.I.** _____

- Specialty**
- | | | |
|---|--|--|
| <input type="checkbox"/> CARDIOLOGY | <input type="checkbox"/> GENERAL SURGERY | <input type="checkbox"/> OBSTETRICS & GYNECOLOGY |
| <input type="checkbox"/> DIAGNOSTIC RADIOLOGY | <input type="checkbox"/> INTERNAL MEDICINE | <input type="checkbox"/> ORTHOPEDIC SURGERY |
| <input type="checkbox"/> EMERGENCY MEDICINE | <input type="checkbox"/> NEPHROLOGY | <input type="checkbox"/> UROLOGIC SURGERY |
| <input type="checkbox"/> FAMILY MEDICINE | <input type="checkbox"/> NEUROLOGY | |
| <input type="checkbox"/> GASTROENTEROLOGY | <input type="checkbox"/> NEUROSURGERY | |

Applying for training period from _____ **to** _____ (enter dates)

General Information

Mailing address _____

City _____ State _____ ZIP _____ Email _____

Preferred telephone (_____) _____ - _____ [] home [] cell AOA # _____

Alternate telephone (_____) _____ - _____ [] home [] cell SSN _____

Pre-Doctoral Education

Undergraduate College _____ City/State _____

Dates attended: from _____ to _____ Degree _____ Major or field _____

Undergraduate College _____ City/State _____

Dates attended: from _____ to _____ Degree _____ Major or field _____

Osteopathic College _____ City/State _____

Dates attended: from _____ to _____ Degree _____ Date of graduation _____

Education interrupted or extended? [] no [] yes (give reason below)

Post-Doctoral Education

Internship [] Traditional Rotating [] Track/Emphasis in _____ [] Other: _____

Institution Name _____ City/State _____

Dates of training: from _____ to _____ AOA-approved internship? [] yes [] no

Program interrupted, extended or incomplete? [] no [] yes (give reason below)

Residency Specialty _____

Institution Name _____ City/State _____

Dates of training: from _____ to _____ Program accredited by [] AOA [] ACGME

Program interrupted, extended or incomplete? [] no [] yes (give reason below)

Licensure and Hospital Privileges

State _____ License number _____ Effective dates _____

State _____ License number _____ Effective dates _____

DEA License Number _____ Effective dates _____

Have you ever had a license suspended or revoked? [] no [] yes

Explain _____

Have you ever been denied hospital privileges or had hospital privileges limited, suspended or revoked?

[] N/A [] no [] yes (explain:)

Honors and Professional Memberships

Research Experience and Publications

Employment and Volunteer Experience

Comments

Describe your reasons for interest in Garden City Hospital.

What are your career plans beyond residency training?

Describe any additional factors that Garden City Hospital should consider in reviewing your application.

Authorization for release of information: By submitting this application for residency training at Garden City Hospital ("Hospital"), I authorize the Hospital to consult with the institutions with which I have been associated as a student, employee, intern, resident, fellow, or physician and with others who may have information bearing on my competency, character and ethical qualifications. I furthermore consent to the Hospital's inspection of all records and documents that may be material to an evaluation of my professional qualifications, competency and moral and ethical qualifications for appointment to residency training. I release from liability all representatives of the Hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluation my application and my credentials. I furthermore release from liability all individuals and organizations who provide information to the Hospital for their acts performed in good faith and without malice in connection with evaluation my application and my credentials.

I certify that the information I have provided is, to the best of my knowledge, correct and complete.

Signature of Applicant _____ **Date** _____

Witness _____ **Date** _____

RETURN APPLICATIONS TO: Garden City Hospital, Department of Medical Education
6245 Inkster Road, Garden City, MI 48135-4001
Phone: 734-458-4486 Fax: 734-458-4496