Cleveland Clinic

9500 Euclid Ave
Cleveland OH 44195

APPLICATION FOR RESIDENCY OR FELLOWSHIP

Please print or type: the application and all supporting documents should be sent directly to the program director

Program Applied For: _____

To begin on _____ at Graduate Level _____

_____ _____ _____
Last Name First Middle (No Initial)

_____ _____ _____ _____ _____
Present Street Address City State Zip Code Country

_____ _____ _____
Home Phone Work Phone Cell Phone

_____ _____
Permanent Address Home Telephone Work Telephone

_____ _____ _____ _____
City State Zip Code Country

_____ _____
E-Mail Address Fax Number (If international, please provide country and city codes)

EDUCATION:

_____ _____ _____ _____ _____ _____
College or University City State Beginning Ending Major

_____ _____ _____ _____ _____ _____
Advanced Degree School City State Beginning Ending Degree Granted

_____ _____ _____ _____ _____ _____
Medical School City State Beginning Ending Degree Granted

CERTIFYING EXAMS:

☐ USMLE ☐ COMLEX ☐ Other: _____

_____ _____ _____ _____
Step or Part 1 Step or Part 2 ck Step or Part 2 cs Step or Part 3

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

_____ _____ _____ _____ _____-_____ ☐ U.S. ☐ International
Program Hospital City State beginning ending

_____ _____ _____ _____ _____-_____ ☐ U.S. ☐ International
Program Hospital City State beginning ending

_____ _____ _____ _____ _____-_____ ☐ U.S. ☐ International
Program Hospital City State beginning ending

_____ _____ _____ _____ _____-_____ ☐ U.S. ☐ International
Program Hospital City State beginning ending

Do you currently hold a medical license? ☐ Yes ☐ No

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

State	License Number	Expiration	State	License Number	Expiration

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

If yes, explain: _____

_____

_____

_____

4. **International Medical Graduates Only:**

Are you certified by the E.C.F.M.G.? ☐Yes ☐No

Certificate number: _____ Certificate issue date: _____

5. Citizen of U.S.? ☐ Yes ☐ No If no, Permanent resident? ☐ Yes ☐ No If yes, Alien number: A#_____

If not a citizen or permanent resident, are you currently in the U.S.? ☐ Yes ☐ No

If so, what is your status?

☐ Exchange Visitor Visa (J-1) ☐ 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

6. **References and Supporting Documents:**

PGYI: Please submit a CV, Personal Statement, Deans Letter, USMLE (or COMLEX) score reports, Transcripts, and at Least 2 letters of recommendation from physicians whom have supervised you in a clinical setting as well as a class standing, if available.

PGYII/above: Please submit a CV, personal statement, Deans letter, USMLE (or COMLEX) score reports, transcripts, a letter of support from your residency program director and at Least 2 letters of recommendation from other physicians whom have supervised you in a clinical setting as well as certificate (or other validation) of all previous training.

INTERNATIONAL GRADUATES:
In addition to the requirements above, please send a certified copy of your E.C.F.M.G. certificate.

REFERENCES AND SUPPORTING DOCUMENTS WILL NOT BE RETURNED.

The policy of the Cleveland Clinic and its system hospitals is to provide equal opportunity to all of our employees and applicants for employment. Decisions concerning employment, transfers and promotions are made upon the basis of the best qualified candidate without regard to color, race, religion, national origin, age, sex, sexual orientation, marital status, ancestry, status as a disabled or Vietnam era veteran or any other characteristic protected by law.

In signing this application I certify that the information given or attached is true, accurate and complete.

Signed _____ Date _____