

Attach Recent
Photograph
(2" x 2")

APPLICATION FOR SUBSPECIALTY RESIDENCY

IN: _____

Starting Date: _____

Name _____

Home Address: _____

Current Address: _____

Date and Place of Birth _____ Health Status _____

Citizenship _____ Marital Status _____

No Dependents _____ Social Security No _____

Academic Year Applying For July, 20____ through June, 20 _____ Other dates _____ through _____

Participating in Fellowship Specialty Match yes _____ no _____

Academic Record (all dates inclusively)

1. College _____

Dates attended _____ Degree _____

2. Medical School _____

Dates Attended _____ Month/Yr Graduated _____ Degree _____

Post-Graduate Training (all dates inclusively)

1. Internship Type _____

a) Name and Location of Hospital _____

b) Dates _____ Director of Training Program _____

2. Residencies (all dates inclusively)

a) Hospital and Address _____ Specialty _____

Director of Residency _____ Dates _____

b) Hospital and Address _____ Specialty _____

Director of Residency _____ Dates _____

3. Fellowships (all dates inclusively)

Location _____

Type _____ Dates _____

4. Specialty Boards in _____

Oral-Year _____ Written-Year _____ Both – Year _____

5. Other Dates With Activities Not Accounted For Above _____

Private Practice (Location, type and dates) _____

Draft Status

1. Active Duty (Branch of Service and Dates) _____ Reserve Status _____
2. Do you hold a Commission? _____ Rank and Type _____
3. Draft Classification _____
4. Address of Draft Board _____

Licensure

Type and Number of ECFMG Certificate(s) _____ Date Issued _____
List States and Date of Licensure _____

Professional Liability

Present Insurance Carrier _____ Amount _____
(Please include a copy of the facesheet of your current policy)

IF THE ANSWER TO ANY OF THE FOLLOWING THREE QUESTIONS IS “YES”, PLEASE GIVE FULL DETAILS ON A SEPARATE SHEET OF PAPER.

Have judgments or settlements been made against you in professional liability cases? Yes No
Has your malpractice insurance coverage ever been terminated by action of the insurance company? Yes No
If “yes”, state when and by what company _____

Have any malpractice suits been filed against you which are presently pending? Yes No
Has your license to practice medicine in jurisdiction ever been limited, suspended or revoked? Yes No
Have your privileges at any hospital ever been suspended, diminished, revoked or not renewed? Yes No
Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization? Yes No

List any publications or abstracts

(If further space is needed, please attach your statement to this form)

What is your ultimate goal after completing the Subspecialty Residency?

List the names and addresses of the two persons whose letters of recommendation will accompany and support this application. These persons must have had recent contact with the applicant.

1) _____

2) _____

The applicant should submit a medical school transcript, a recent photograph at least two inches square (place on the front page) and 2 letters of recommendation (one should be from the Program Director). Letters should be requested from those designated above at the time of application. Send copies of current passport, visa H1 or J1 or work permit (enlarged), ECFMG certificate, (Missouri permanent license, BNDD, DEA) or do you plan on applying for a Temporary License while in fellowship program, ACLS/BLS card and H1 (copy of I-797C Notice of Action)

I FULLY UNDERSTAND THAT ANY SIGNIFICANT MISSTATEMENT IN OR OMISSION FROM THIS APPLICATION CONSTITUTES CAUSE FOR SUMMARY DISMISSAL FROM THE TRAINING PROGRAM

Signature _____ Print Name _____

Address to which correspondence is to be sent:

Email Address _____

Home Telephone _____

Work Telephone _____

Pager _____

PLEASE KEEP US INFORMED OF ANY CHANGES IN ADDRESS

Return To

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