Beaumont

APPLICATION FOR POSTGRADUATE MEDICAL EDUCATION

NAME IN FULL _____
Last First Middle

Home Address _____
Number Street City State Zip Code Phone Number

Mailing Address *(if different from home address):*

_____
Number Street City State Zip Code Phone Number

_____ _____
Social Security Number E-mail address

This application is for:

☐ Transitional Year

☐ Preliminary Specialty _____

☐ Categorical Specialty _____

☐ Fellowship Specialty _____

at ___ (1st, 2nd, etc.) postgraduate year level, to begin training July 1, 20 __ or _____ .

Photograph

Optional

Are you a citizen of the United States or otherwise permitted by visa to study in the United States? ☐ Yes ☐ No

If you are permitted to study in the United States pursuant to a visa, please state:

Type Visa _____ Date first obtained _____ Expiration Date _____

Do you have any impairments (physical, mental or medical) which require accommodation in order for you to complete your postgraduate training program successfully? ☐ Yes ☐ No
(if you require an accommodation, please attach a written explanation.)

LICENSURE INFORMATION _____
Number Date Conferred State Description (Temporary or Permanent)

Have you ever been denied a license to practice medicine, or had your license restricted in any way? ☐ Yes ☐ No
(If yes, attach a written explanation.)

RESULTS OF U.S. MEDICAL LICENSURE EXAM: Step 1 _____ _____ Step 2 _____ _____
Total Score Date Total Score Date

Step 3 _____ _____
Total Score Date

If you have taken an examination other than the USMLE (e.g. NBME, FLEX, or ECFMG), attach date(s), score(s), and certificate(s).

Have you signed an agreement with the NATIONAL RESIDENT MATCHING PROGRAM? ☐ Yes ☐ No

If so, what is your NRMP number? _____

PREMEDICAL EDUCATION

College or University	Location	Dates (From-To)	Degree	Class Standing

MEDICAL EDUCATION (List all medical schools attended, and for any from which you did not graduate, state the reason for leaving.)

Medical School	Location	Dates (From-To)	Degree	Class Standing

Academic Honors _____

POSTGRADUATE TRAINING (List all postgraduate training.)

First Postgraduate Year:

Institution	Location	Dates (From-To)	Type of Program

Residencies and/or Fellowships

1)

Institution	Location	Dates (From-To)	Type of Program

2)

Institution	Location	Dates (From-To)	Type of Program

3)

Institution	Location	Dates (From-To)	Type of Program

4)

Institution	Location	Dates (From-To)	Type of Program

OTHER MEDICAL EXPERIENCES (Research, practice, etc. Give type, place and dates):

PUBLICATIONS AND RESEARCH CONDUCTED (Give Title, periodical, pages, date, etc.):

REQUIREMENTS FOR APPLICATION:

1. Attach a copy of USMLE scores.
2. One letter should be sent by the Dean of your medical school with a current transcript and, if applicable, medical school diploma.

   Three additional letters of reference should be sent by staff or faculty members with whom you have worked closely. If you have had any postgraduate training, one of the three additional letters should be from the person who is supervising your current year of training (or person who supervised your most recent year of clinical training).
3. Written verification of any postgraduate clinical training obtained in U.S. hospitals.

Please return this application with the above materials and any other inquiries or replies to: (Name of Director; Name of Residency/Fellowship)
William Beaumont Hospital
3601 West Thirteen Mile Road
Royal Oak, Michigan 48073-6769

By my signature below, I attest that the information provided is complete and accurate.

Signature _____ **Date** _____