Beaumont Hospital
Farmington Hills

Beaumont

APPLICATION FOR TRAINING

BEAUMONT HOSPITAL, FARMINGTON HILLS
28050 Grand River Avenue
Farmington Hills, Michigan 48336-5933
(248) 471-8224

PERSONAL DATA (Please print or type)

Last Name ____________ First Name ____________ S.S.# ____________

Permanent Home Address ____________
NUMBER STREET

____________ Phone (_____) ____________
CITY OR TOWN STATE ZIP CODE

Present Address ____________
NUMBER STREET

____________ Phone (_____) ____________
CITY OR TOWN STATE ZIP CODE

E-mail Address ____________

PRE-DOCTORAL OSTEOPATHIC EDUCATION

College of Osteopathic Medicine ____________ Years Attended (Month/Year) ____________

City, State ____________

Graduation Date ____________

TYPE OF TRAINING REQUESTED (Request one)

☐ Residency From ____________ (MONTH/YEAR) To ____________ (MONTH/YEAR) Residency in: ____________

☐ Subspecialty Residency From ____________ (MONTH/YEAR) To ____________ (MONTH/YEAR) Residency in: ____________

PRE-OSTEOPATHIC EDUCATION

School	Address (City/State)	Dates Attended	Degree	Major
HIGH SCHOOL				
COLLEGE OR UNIVERSITY				
GRADUATE SCHOOL				

TO BE COMPLETED BY RESIDENT AND SUBSPECIALTY RESIDENT APPLICANTS ONLY

Internship ______________ A.O.A. Approved: ____ ____ Dates ______________
HOSPITAL YES NO

______________ (____) ______________
ADDRESS CITY STATE ZIP CODE PHONE

☐ Traditional (Rotating)

☐ Emphasis Internship: ______________
TYPE

☐ Specialty Track: ______________
TYPE

Name of Director of Medical Education ______________

Residency ______________ A.O.A. Approved: ____ ____ Dates ______________
HOSPITAL YES NO

______________ (____) ______________
ADDRESS CITY STATE ZIP CODE PHONE

Specialty ______________ Certificate of completion received? ____ ____
YES NO

Name of Program Director ______________

LICENSURE/A.O.A. MEMBERSHIP

______________ ______________
STATE LICENSE NUMBER

______________ ______________
STATE LICENSE NUMBER

My A.O.A. membership number is: ______________

REFERENCES (Minimum of three physicians) *No more than one is to be from the faculty of the school attended.*

______________ ______________
NAME COMPLETE ADDRESS

______________ ______________
NAME COMPLETE ADDRESS

______________ ______________
NAME COMPLETE ADDRESS

OTHER INFORMATION

Have there been any interruptions in the continuum of your pre-doctoral or post-doctoral education? ______ YES ______ NO ____________ IF YES, PLEASE EXPLAIN WHAT AND WHY

Are you a U.S. citizen? ______ YES ______ NO ____________ IF NO, THEN STATUS

Do you have military commitment upon graduation? ______ YES ______ NO

Do you have a public health commitment? ______ YES ______ NO

Are you BCLS certified? ______ YES ______ NO ____________ IF YES, EXPIRATION DATE

Are you ACLS certified: ______ YES ______ NO ____________ IF YES, EXPIRATION DATE

Are you a certified instructor? ______ YES ______ NO ____________ IF YES, EXPIRATION DATE

Please list below any research experience you may have and papers you have written.
Attach bibliography or abstracts of papers written or published.

____

____

____

____
SIGNATURE

____
DATE OF APPLICATION

____
REVIEWED BY MEDICAL EDUCATION
(SIGNATURE AND DATE)