Instruction for Completion of Application for Appointment to Graduate Medical Education at University of North Carolina Hospitals

Chapel Hill, North Carolina 27514

Complete all required information on the application form. Select a position and service from the list below and indicate it on the application form.

Options for Position and Service Desired:

Position	Service			
1st Year Post Graduate	Allergy & Immunology	Hematology/Oncology	Female Pelvic Medicine &	Pediatric Pulmonary
2nd Year Post Graduate	Anesthesiology	Infectious Diseases	Reconstructive Surgery	Physical Medicine and
3rd Year Post Graduate	Anesthesiology/Pain Med	Interventional	Ophthalmology	Rehabilitation
4th Year Post Graduate	Anesthesiology/Pediatric	Cardiology	Orthopaedics	Plastic Surgery
5th Year Post Graduate	Dentistry	Nephrology	Otolaryngology -	Preventive Medicine
6th Year Post Graduate	General Practice	Pulmonary Disease,	Head and Neck Surgery	Psychiatry
7th Year Post Graduate	Pediatric Dentistry	Critical Care	Pathology – Anatomical &	Adult
8th Year Post Graduate	Oral Maxillofacial Surgery	Rheumatology	Clinical	Child & Adolescent
Subspecialty Resident:	6 year program	Transplant Hepatology	Blood Banking/	Forensic
Year 1	Dermatology	Internal Medicine/	Transfusion Med.	Psychosomatic
Year 2	Emergency Medicine	Pediatrics	Cytopathology	Radiology – Diagnostic
Year 3	Pediatric Emergency	Medical Genetics	Forensic Pathology	Neuroradiology
Fellow	Medicine	Medical Biochemical	Hematology/Pathology	Vascular/Interventional
(non ACGME Program)	Family Medicine	Genetics	Pediatrics (1 yr)	Radiation/Oncology
	Sports Medicine	Molecular Genetic	Pediatrics (3 yrs)	Sleep Medicine
	Internal Medicine (1 yr)	Pathology	Pediatrics/Anesthesiology	Surgery – General
	Internal Medicine (3 yrs)	Neurological Surgery	(Combined 5 yr)	Surgery – Critical Care
	Cardiovascular Disease	Neurology	Neonatology/Perinatal	Surgery – Vascular
	Clin. Cardiac Electrophys.	Adult Neurology	Nephrology	Cardiothoracic Surgery
	Endocrine, Diabetes,	Child Neurology	Pediatric Critical Care	Integrated
	Metabolism	Vascular Neurology	Pediatric Endocrinology	Urology
	Gastroenterology	Ob/Gyn	Pediatric Hematology/	Non-ACGME Program
	Geriatric Medicine		Oncology	

Applicants applying for 1st Year Post Graduate Positions must mail directly to the Training Program to which you are applying the following documents:

1. Application for Graduate Medical Education at the University of North Carolina Hospitals; and
2. Three letters of reference.
   a. One letter of reference must be mailed from the Dean or designee of the School of Medicine/Dentistry from which the applicant graduated; and
   b. One letter of reference must be mailed from the Chair or designee in the chosen specialty at the Medical/Dental School from which the applicant graduated; and
   c. A third letter of reference from someone who has knowledge of your experience, ability, educational accomplishments and character.
3. An official, final Medical/Dental School transcript from the Registrar of the school of Medicine or Dentistry. A photocopy is not acceptable. The transcript must be mailed directly to the program.
4. A current CV that includes the date or anticipated date of Medical/Dental School graduation and name of UNC Hospitals residency program the applicant will enter.
5. A recent photograph is helpful but not required.
6. Read carefully and sign the Authorization for Release of Information.

Applicants applying for above 1st-Year Post Graduate Positions, including applicants who are changing specialties, must mail directly to the Training Program to which you are applying the following documents:

1. Application for Graduate Medical Education at the University of North Carolina Hospitals; and
2. Three letters of reference.
   a. One letter of reference must be mailed from program director of the residency program in which the applicant has most recently served; and
   b. Two letters of reference must be mailed from members of the medical or dental staff of the hospital affiliated with the sponsoring institution of that residency program.
3. An official, final Medical/Dental School transcript from the Registrar of the School of Medicine or Dentistry. A photocopy is not acceptable. The transcript must be mailed directly to the program.
4. A current CV that includes the date or anticipated date of Medical/Dental School graduation and name of UNC Hospitals residency program the applicant will enter.
5. A recent photograph is helpful but not required.
6. Read carefully and sign the Authorization for Release of Information.

The responsibility for securing letters of reference rests with the applicant. All letters of reference, transcripts and supporting documents should be addressed directly to the Chief of Service or Director of the Training Program in which the applicant is interested. DO NOT have recommendation letters sent directly to the Director of Graduate Medical Education or just to UNC Hospitals.

Apply to only one training program on a single application.

Position Applying for _____

Training Program _____

Anticipated Starting Date _____

Name _____
Last First Middle

Medical and Dental Education

School _____

Degree _____

Date_____

Applicant Address

_____

_____
School or Hospital Address

_____

_____
Present Home Address (mailing)

Telephone

_____
Dean's Office or School # where you can be reached

_____
Home #

_____
Fax #

_____
Email Address

Date of Birth _____

Place of Birth _____

U.S. Citizen Yes ☐ No ☐
If not a citizen,

Type of Visa _____

*Note: The H-1B visa is not accepted for graduate medical education programs at UNC Hospitals.

Are you registered with any Matching Program?

Yes ☐ No ☐ If yes, which one?
NRMP _____ Other _____ (list)
_____

Attention Couples:

If you want your application considered in conjunction with that of another person, please provide the following information about that person:

Name _____

Program _____

College Education

School _____

Major _____

Degree _____

Date _____

Class Standing _____

Other Graduate School and Postgraduate Education and Training

Please list all residency and subspecialty training:

Program _____

Place _____

Date _____

Satisfactorily Completed _____

Program _____

Place _____

Date _____

Satisfactorily Completed _____

Program _____

Place _____

Date _____

Satisfactorily Completed _____

Professional Experience – Teaching Appointments & Practice
(Other than Medical/Dental Trainee Status)

Employer _____

_____
Address (City, State and ZIP Code)

Phone _____

Position _____

Full or Part Time _____

_____
Dates Employed: From (Month/Day/Year) to (Month/Day/Year)

Reason for Leaving _____

Employer _____

_____
Address (City, State and ZIP Code)

Phone _____

Position _____

Full or Part Time _____

_____
Dates Employed: From (Month/Day/Year) to (Month/Day/Year)

Reason for Leaving _____

Employer _____

_____
Address (City, State and ZIP Code)

Phone _____

Position _____

Full or Part Time _____

_____
Dates Employed: From (Month/Day/Year) to (Month/Day/Year)

Reason for Leaving _____

Names of references from whom we may expect letters:
See requirements on page 1

_____
Name

_____
Title

_____
Name

_____
Title

_____
Name

_____
Title

Honors, Professional Awards and Memberships

_____

_____

_____

Have you taken Part III of the Medical National Boards or USMLE?

Yes ☐ No ☐ Not Applicable ☐

Date _____ Score _____

Medical or Dental National Boards Parts I & II or USMLE/COMLEX dates and scores:

Part I _____

Part II _____

Have you taken any parts more than once? If so, give dates and scores:

_____

_____

_____

Attach a recent photograph

(Optional)

Foreign Graduates:
Have you taken and passed VISA Qualifying Exams or FMGEMS?
Yes ☐ No ☐ Score _____

Have you taken and passed ECFMG Exam?
Yes ☐ No ☐

ECFMG Certificate Number _____

Date _____

Licensure/DEA Registration
Have you ever been licensed in any state prior to the date of this application? Yes ☐ No ☐

If yes, please provide the following for each:

Type of License/State/Number _____

_____

Do you have or have you ever had any license revoked, suspended, denied, restricted, limited or issued/placed in a probationary status or voluntarily relinquished?
Yes ☐ No ☐ N/A ☐

If yes, attach a full explanation to this application.

Have you ever been issued a Federal DEA number?
Yes ☐ No ☐

If yes, provide number _____

Has your Federal DEA registration ever been limited, suspended or revoked? Yes ☐ No ☐ N/A ☐
If yes, attach a full explanation to this application.

Research or Experimental Work*:

_____

_____

Publications and Presentations*:

_____

_____

Statement of Career Goals and type of Graduate Educational Programs desired*:

_____

_____

Extracurricular interests*:

_____

_____

Statement regarding general health and physical ability*:

_____

_____

[*You may wish to attach a detailed personal statement.]

Military Experience or National Health Programs (NIH, PHS, IHS, etc.)

_____

_____

Type of Discharge _____
Subject to active duty? Yes ☐ No ☐

Are you able, physically and mentally, to practice safely and competently with or without reasonable accommodation?

Yes ☐ No ☐ (explain) Uncertain ☐ (explain)

_____

_____

Have you ever been convicted or pleaded guilty to a violation of Federal, State, or Local Law other than minor traffic violations?

Yes ☐ (explain) No ☐

_____

_____

Have you ever been CHARGED with driving under the influence or while impaired?

Yes ☐ (explain) No ☐

_____

_____

Have you ever been voluntarily or involuntarily placed on probation, suspended or terminated from a Medical/Dental School Residency Program or Medical or Dental Staff?

Yes ☐ (explain) No ☐

_____

_____

If it took more than four years to complete Medical or Dental School, please explain:

_____

_____

Professional Sanctions/Charges/Violations

Are you now, or have you ever been, involved in any litigation, lawsuits, claims or arbitration related to your professional activities? Yes ☐ (explain) No ☐

_____

_____

Have judgments or settlements been made against you in professional liability cases or are you involved in any pending litigation? Yes ☐ (explain) No ☐

_____

_____

Have you ever been denied liability insurance?

Yes ☐ (explain) No ☐

_____

_____

Has your membership or renewal thereof in any medical organization ever been revoked, suspended, diminished or denied? Yes ☐ (explain) No ☐

_____

_____

Have your privileges in any hospital ever been suspended, diminished, revoked or not renewed? Yes ☐ (explain) No ☐

_____

_____

_____

Please notify the training program immediately if any of your responses on this application change.

Authorization for Release of Information

By applying to a residency/fellowship program at the University of North Carolina Hospitals, I hereby signify my willingness to appear for interviews in connection with my application. I hereby authorize the Hospital, the Schools of Medicine/Dentistry of the University of North Carolina at Chapel Hill and their representatives to consult with administrators and members of the medical staffs of other hospitals or institutions with which I have been associated and with any and all others, including but not limited to: past and present malpractice carriers, educational institutions and residency programs which may have information bearing on my professional competence and experience, my character, my mental and/or emotional health, my physical health, my ethical qualifications, and my ability to work with others.

I consent to the inspection by the Hospital, the Schools of Medicine/Dentistry of the University of North Carolina at Chapel Hill and their representatives of any and all documents, including medical records at other hospitals that may be relevant to an evaluation of my professional, moral and ethical qualifications.

I hereby release from liability all representatives of the Hospital and the Schools of Medicine/Dentistry for their acts performed in good faith in evaluating my application, my credentials and my qualifications. I also hereby release from liability all individuals and organizations who provide information, including otherwise privileged or confidential information to the Hospital and the Schools of Medicine/Dentistry in good faith and without malice concerning my professional status or other qualifications, and hereby consent to the release of such information.

I certify that all statements on this application are true and complete to the best of my knowledge. I understand that any misstatements in, omissions to, or falsification of, any document related to this application may result in rejection of my application or my dismissal if I am employed. I understand if I am employed by the University of North Carolina Hospitals or the University of North Carolina Schools of Medicine/Dentistry, I will be required to produce original documents verifying (1) my identity, and (2) either United States Citizenship or authorization to work in the United States, in compliance with Federal Immigration Reform and Control Act of 1986.

I understand that if I am accepted into Graduate Medical Education at UNC Hospitals it is mandatory that I immediately provide my Social Security Number to the Office of Graduate Medical Education because UNC Hospitals must disclose my Social Security Number pursuant to various federal and state laws involving taxes, income, and debt owed to the state. Accordingly, upon my admission to UNC Hospitals Graduate Medical Education, I will immediately and voluntarily provide my Social Security Number to the Office of Graduate Medical Education.

Signature _____

(*This document must be hand-signed)

Please Print _____

Date _____

Completed application should be mailed to:

Residency Program Director

_____

(Clinical Department Name)

University of North Carolina, Chapel Hill, NC 27599 USA

Authority for Release of Information

Name (First, Middle, Last) _____

Maiden Name (if applicable) _____

Current Address _____ How Long? _____

City, County, State, Zip _____

Previous Address #1 _____ How Long? _____

City, County, State, Zip _____

Previous Address #2 _____ How Long? _____

City, County, State, Zip _____

Applicant Social Security Number _____-_____-_____ Date of Birth _____/_____/_____

Driver License Number and State Issued _____

***If you have a Pennsylvania, New Hampshire or Washington License, please contact the OGME at 919-966-1072**

Applicant Authorization

I hereby authorize UNC Hospitals' Office of Graduate Medical Education to utilize a Consumer Reporting Agency (CRA) to verify my past and present driving records and any information I have provided. I also authorize the CRA to perform a criminal records search.

I understand the CRA does not guarantee the accuracy or timeliness of the information obtained from other sources and that the Office of Graduate Medical Education shall not be liable for any inaccuracy in the information obtained from other sources that is included in the consumer report.

Further, I authorize my current and former employers as well as other organizations to provide such information to the CRA and I hereby release and hold harmless UNC Hospitals, the CRA, and my current and former employers as well as other organizations who have provided information on account of the collection or use of such information in connection with my consumer report.

I further authorize UNC Hospitals' Office of Graduate Medical Education to share information collected pursuant to this application process that may be relevant to an evaluation of my professional, moral and ethical qualifications as a resident/subspecialty resident in a UNC Residency Program with representatives from the University of North Carolina at Chapel Hill, and in particular the UNC Schools of Dentistry and Medicine, as appropriate. I hereby release and hold harmless UNC Hospitals in the event it shares such information with representatives of the University of North Carolina at Chapel Hill as part of evaluating my application.

Consumer Disclosure

I understand that a pre-employment consumer report may be obtained by UNC Hospitals from a Consumer Reporting Agency for employment purposes.

_____ _____/_____/_____

Applicant's Signature (*This document must be hand-signed) Date

_____

Department Name