**UNIVERSITY AT BUFFALO**

**THE STATE UNIVERSITY OF NEW YORK**

**APPLICATION TO GRADUATE MEDICAL/DENTAL RESIDENCY PROGRAMS**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | Clinical \_\_\_\_ |
| Position Desired: | Resident | Fellow: | Research \_\_\_\_ |

Application for Position in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Specialty)

Years of Training Desired: \_\_\_\_\_\_\_\_\_\_\_

Postgraduate Year for Which You Are Applying: I II III IV V VI

Starting Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are You Participating In NRMP (National Resident Matching Program)?

|  |  |  |
| --- | --- | --- |
| Yes \_\_\_ | No \_\_\_ | Number \_\_\_\_\_\_\_\_\_\_\_ |

**PERSONAL**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last Name – Surname) (First Name) (Middle Initial) (Social Security Number)

Is additional information relative to change of name, use of assumed name of nickname necessary to enable a check on your work or academic record? If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you 18 years of age or older? If not, state your age: \_\_\_\_\_\_\_\_\_\_\_ Are you a citizen of the United States? \_\_\_\_\_

Present Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permanent Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number- Work: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can you perform reasonably any task expected of a resident in your residency program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Have you ever been convicted of a crime? | Yes \_\_\_\_ | No \_\_\_\_ |

If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Military Service – Current Status and Future Obligation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Branch/Date/Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EDUCATION** (Official transcript with seal must be sent from all institutions attended excluding high school and college Bachelor’s degree\*)

|  |  |  |  |
| --- | --- | --- | --- |
| **Name and Location** | **Dates Attended** | **Major** | **Degree Date** |
| High School/Secondary School: |  |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| College/University: |  |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Graduate School: |  |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medical/Dental School: List all medical schools attended. | Percentile Rank \_\_\_\_\_\_\_\_\_\_\_ (if available) |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other Experience: |  |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

\*Official transcript required for graduate Medical/Dental education only.

List postgraduate professional experience: (including internship, residencies, and research experience).

| **Type of Program** | **Hospital****Or****Institution** | **Complete****Address****Including Country** | **Supervisor/****Program Director Dates (including telephone/area code)** | **PGY****Level** |
| --- | --- | --- | --- | --- |
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|  |  |  |  |  |

List other professional institutional/hospital appointments you have held (excluding graduate training):

| **Hospital** | **Location (Exact Address)** | **Department** | **Dates** |
| --- | --- | --- | --- |
|  |  |  |  |
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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **LICENSURE** |  |  |  |  |
| Flex Examination: |  |  |  |  |
| (Federal Licensure Exam) | Yes \_\_\_ | No \_\_\_ | Date Taken \_\_\_\_\_\_\_\_\_\_\_ | Score \_\_\_\_\_\_\_\_\_\_\_\_ |
| NBME (National Board of Medical Exams) | Part I | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Score \_\_\_\_\_\_\_\_\_\_\_\_ |
| (enclose transcript) |  | Part II | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Score \_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | Part III | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Score \_\_\_\_\_\_\_\_\_\_\_\_ |
| USMLE (United States Medical Licensing | Part I | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Score \_\_\_\_\_\_\_\_\_\_\_\_ |
| Examination) |  | Part II | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Score \_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | Part III | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Score \_\_\_\_\_\_\_\_\_\_\_\_ |
| NBDE (National Board of Dental Exams) | Part I | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Score \_\_\_\_\_\_\_\_\_\_\_\_ |
| (enclose transcript) |  | Part II | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Score \_\_\_\_\_\_\_\_\_\_\_\_ |
| New York State: |  |  |  |  |
| License: | Yes \_\_\_ | No \_\_\_ | Date Taken \_\_\_\_\_\_\_\_\_\_\_ | Number \_\_\_\_\_\_\_\_\_\_ |
| Temporary Permit: | Yes \_\_\_ | No \_\_\_ | Date Taken \_\_\_\_\_\_\_\_\_\_\_ | Number \_\_\_\_\_\_\_\_\_\_ |
| Other States: |  |  |  |  |
| License: | Yes \_\_\_ | No \_\_\_ | Date Taken \_\_\_\_\_\_\_\_\_\_\_ | Number \_\_\_\_\_\_\_\_\_\_ |
| Temporary Permit: | Yes \_\_\_ | No \_\_\_ | Date Taken \_\_\_\_\_\_\_\_\_\_\_ | Number \_\_\_\_\_\_\_\_\_\_ |
| State: \_\_\_\_\_\_\_\_\_ |  |  |  |  |

PROFESSIONAL LIABILITY/DISCIPLINARY ACTION

Please complete the following questions as part of the credentialing process:

1) Have you ever been dismissed from or the subject of disciplinary action (ie: including termination or probation)

while you were in graduate or medical school training? Yes \_\_\_ No \_\_\_ If yes, please provide substantive information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) Have you ever been the subject of actions resulting from professional misconduct or are there any such cases

pending? Yes \_\_\_ No \_\_\_ If yes, please provide substantive information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have there been any settlements or judgments made against you in cases involving medical malpractice or are there any case pending?

Yes \_\_\_ No \_\_\_

If yes, please provide substantive information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**REFERENCES** (under separate cover)

*Please forward*:

Dean’s letter (accompanied by official transcript with seal);

Three professional references (including, if possible, Chief(s) of Service);

Letter from head of clinical service on which you recently served.

I hereby waive access to the above letters and will so inform the authors.

I desire access to the above letters and will so inform the authors.

PERSONAL STATEMENT

Please provide a brief description of your interest in the medical/dental specialty you are applying for as a

career and include both your previous and current academic research or interests. In addition, you may desire to

briefly note any aspects of your training, experience, or plans not requested in this application which you feel may be

of concern to the Selection Committee. (Include honors, publications, and research experience.) Please use

additional sheet(s).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to a copy of this application being provided to the entity that employs me if I am accepted into a UB medical/dental residency/fellowship program.

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Must be original)

I certify that the information submitted on these application materials is complete and correct to the best of my knowledge. I understand that false, missing or misleading information may disqualify me for this position and/or if accepted into a graduate medical/dental residency/fellowship program will result in my dismissal from my program.

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Must be original)

PERSONAL STATEMENT