The following documentation must be mailed directly to the Training Program to which you are applying.

1. Application for Housestaff Appointment.
2. Three letters of reference.
   a. One letter of reference should be mailed from the Dean of the School of Medicine/Dentistry from which the applicant graduated certifying the degree awarded or anticipated date.
   b. One letter of reference must be mailed from the Chairman in the chosen specialty at the Medical/Dental School from which the applicant graduated.

In case of advanced applicants, one letter should be mailed from the hospital in which the applicant is on the medical staff or in training.

The responsibility for securing letters of reference rests with the applicant and 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. This hospital does not have a central office where applications are reviewed. Each clinical department handles its own applicants.

3. An official 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 department.
4. A recent photograph is helpful but not required.
5. Read carefully and sign the Authorization for Release of Information.
Apply to only one department on a single application.

Position Applying for ________________________________

Training Program ________________________________

Anticipated Starting Date __________________________

Name ____________________________________________

Last Name ________________________________________

First Name ________________________________________

Middle Name ______________________________________

Medical/Dental Education

School ____________________________________________

Degree ____________________________________________

Date ______________________________________________

Applicant Address

__________________________________________________

__________________________________________________

School or Hospital Address

__________________________________________________

__________________________________________________

Present Home Address

__________________________________________________

__________________________________________________

Telephone

Dean’s Office or School # where you can be reached

__________________________________________________

__________________________________________________

Fax Number ________________________________________

Date of Birth ________________________________________

Place of Birth ________________________________________

Soc. Sec. No. ________________________________________

U.S. Citizen

Yes ☐ No ☐

If not a citizen,

Type of Visa ________________________________________

Are you registered with:

NRMP ☐ OMP ☐ NMS ☐ (circle one)

Yes ☐ # ____________________ No ☐

University of North Carolina Hospitals

Application for Housestaff appointment

Attention Couples:

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

Name ____________________________________________

Service ____________________________________________

College Education

School ____________________________________________

Major ____________________________________________

Degree ____________________________________________

Date ______________________________________________

Class Standing _______________________________________ 

Other Graduate School and Postgraduate Education and Training

Please list residences (type), subspecialty training (type), teaching appointments or experiences in general practice.

Program __________________________________________

Place ______________________________________________

Date ______________________________________________

Degree Earned/Satisfactorily Completed ______________________________

Program __________________________________________

Place ______________________________________________

Date ______________________________________________

Degree Earned/Satisfactorily Completed ______________________________

Program __________________________________________

Place ______________________________________________

Date ______________________________________________

Degree Earned/Satisfactorily Completed ______________________________

UNC Hospitals Housestaff Application 2003/2004
Names of references from whom we may expect letters:

1. Dean's letter will be from:
   Name
   Title

2. Chairman's letter will be from:
   Name
   Title

3. Third reference:
   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 dates and scores:
Part I ________________________________________________
Part II _______________________________________________

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

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

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

Are you licensed to practice in any states? Please list:
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________

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 warned by the Drug Enforcement Administration (US or State) or has any portion of your Controlled Substances Registration Certificate been denied, revoked, suspended, or surrendered?
Yes □  (explain)  No □

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 voluntarily or involuntarily suspended from a Residency Program or Medical Staff?
Yes □  (explain)  No □

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

Please notify your department immediately if any of your responses on this application change.

Authorization for Release of Information

By applying to the Housestaff of 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 administrative officers and members of the medical staffs of other hospitals or in institutions with which I have been associated and with any and all others, in cluding but not limited to: past and present malpractice carriers, educational institutions and residency programs which may have放入 formation bearing on my professional competence and experience, my character, my mental and/or emotional health, my physical health, my ethical and/or moral 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 all and any documents, in cluding 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 other privileged or confidential information to the Hospital and the Schools of Medicine/Dentistry in good faith and with out 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 or omissions to, or falsification of, any documents related to this application may result in rejection of my application or my dismissal if I am employed. I understand that the United States Citizenship and Immigration Service may have information pertaining to my professional status or other qualifications. I also hereby authorize the Hospital, the Schools of Medicine/Dentistry of the University of North Carolina and the Schools of Medicine/Dentistry of the University of North Carolina to release pertinent information to the Hospital and the Schools of Medicine/Dentistry in good faith and with out malice concerning my professional status or other qualifications, and hereby consent to the release of such information.

I hereby authorize the release of all personal information for processing purposes.

Signature: __________________________
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, State, Zip __________________________________________
Previous Address #1 ____________________________________ How Long? ________________
City, State, Zip __________________________________________
Previous Address #2 ____________________________________ How Long? ________________
City, State, Zip __________________________________________
Applicant Social Security Number ______ / ______ / _______ Date of Birth ______ - ______ - ______
Driver License Number and State Issued ____________________________

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 that 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.

Consumer Disclosure

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

Applicants Signature ________________________________ Date ______ / ______ / ______

Department Name

For office use only

Fax to Insight at 1-800-888-3487

Faxed OGME Account Number ZZ65855

UNC Hospitals

☐ Criminal History ☐ Motor Vehicle Record

Criminal (1) ___________________ (2) ___________________ (3) ___________________