Instruction for Completion of Application for Appointments to the Housestaff of the 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 2nd Year Post Graduate 3rd Year Post Graduate 4th Year Post Graduate 5th Year Post Graduate 6th Year Post Graduate 7th Year Post Graduate 8th Year Post Graduate Subspecialty Resident: Year 1 Year 2 Year 3	Anesthesiology Anesthesiology Pediatrics Anesthesiology Pain Mgmt Dentistry General Practice Pediatric Dentistry Oral Maxillofacial Surgery Dermatology Emergency Medicine Family Practice Medical Genetics Internal Medicine (1yr) Internal Medicine (3yrs) Cardiovascular Disease Endocrine, Diabetes, Metabolism Gastroenterology Infectious Diseases Nephrology	Rheumatology Geriatric Medicine Interventional Cardiology Clinical Cardiac. Electro. Hematology/Oncology Pulmonary Disease, Critical Care Neurological Surgery Neurology Adult Neurology Child Neurology Molecular Genetic Pathology Nuclear Medicine Ob/Gyn Ophthalmology Otolaryngology	Pathology - Anatomical & Clinical Blood Banking/ Transfusion Med. Cytopathology Forensic Pathology Hematology/Pathology Neuropathology Pediatrics (1yr) Pediatrics (3yrs) Pediatric Critical Care Pediatric Endocrinology Pediatric Hematology/ Oncology Neonatology/Perinatal Pediatric Pulmonary Pediatric Gastroenterology Pediatric Sports Medicine	Physical Medicine and Rehabilitation Plastic Surgery Preventive Medicine Psychiatry Adult Child & Adolescent Diagnostic Radiology Neuroradiology Vascular/Interventional Radiation Oncology Surgery - General Surgery - Critical Care Surgery - Vascular Cardiothoracic Surgery Urology Internal Medicine Pediatrics

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.

   c. A third letter of reference.

   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 First Middle

Medical/Dental Education

School _____

Degree _____

Date _____

Applicant Address

_____

_____
School or Hospital Address

_____

_____
Present Home Address (mailing)

_____

_____
Present Home Address

Telephone

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

_____
Home #

_____
Fax Number

_____
Internet Address

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 ☐

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 _____

Program _____

Place _____

Date _____

Degree Earned/
Satisfactorily Completed _____

Names of ref er ences from whom we may ex pect let ters:

1. Dean's let ter will be from:

_____
Name

_____
Title

2. Chair man's let ter will be from:

_____
Name

_____
Title

3. Third ref er ence:

_____
Name

_____
Title

Honors, Pro fes sional Awards and Mem ber ships

_____
_____
_____
_____
_____

Have you taken Part III of the Med i cal Na tional Boards or USMLE?

Yes ☐ No ☐ Not Ap pli ca ble ☐

Date _____ Score

Med i cal or Den tal Na tional 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:

_____
_____
_____
_____

For eign Grades:
Have you taken and passed VISA Qualifying Exams or FMGEMS?

Yes ☐ No ☐ Score _____

Have you taken and passed ECFMG Exam?

Yes ☐ No ☐

Score _____

Attach a recent photograph
(optional)

Are you Li censed to prac tice in any states? Please list:

_____
_____
_____

Research or Ex per i men tal Work*:

_____
_____
_____

Publications and Presentations*:

_____
_____
_____

Statement of Ca reer Goals and type of Grad u ate Edu ca tional Pro grams desired*:

_____
_____
_____

Extracurricular interests*:

_____
_____
_____

Statement regard ing gen eral health and phys i cal abil ity*:

_____
_____
_____
_____

*** You may wish to at tach a de tailed per sonal state ment.**

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.

HD 4893 Rev 09/02

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 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 it is mandatory that UNC Hospitals disclose my Social Security Number pursuant to various federal and state laws involving taxes, income, and debts owed to the state. I voluntarily authorize UNC Hospitals to use my Social Security Number in the future as a personal identifier for internal record keeping and data 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) _____