



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

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.

University of North Carolina Hospitals Application for Housestaff appointment

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 refer 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 refer 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:

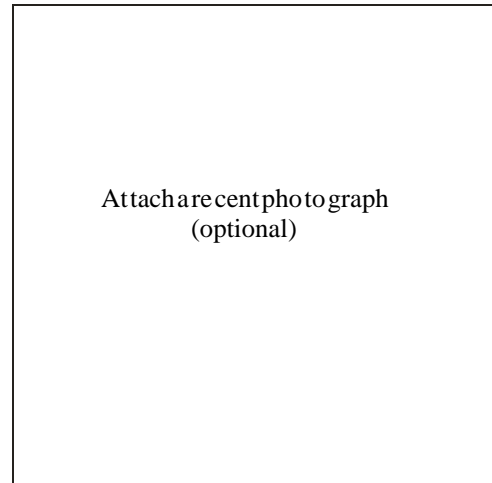
Have you taken and passed VISA Qualifying Exams or FMGEMS?

Yes No Score _____

Have you taken and passed ECFMG Exam?

Yes No

Score _____



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 Educa tional Programs desired*:

Ex tra cur ricu lar in ter ests*:

Statement re gard 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.

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 In sight at 1-800-888-3487
Faxed	OGME Account Number ZZ65855
UNC Hospitals	
<input type="checkbox"/> Criminal History	<input type="checkbox"/> Motor Vehicle Record
Criminal (1) _____	(2) _____ (3) _____