Jackson
MEMORIAL HOSPITAL
Jackson Health System

PUBLIC HEALTH TRUST

1611 N.W. 12th Avenue,
Miami, Florida 33136-1096

APPLICATION FOR GRADUATE MEDICAL EDUCATION AT THE PUBLIC HEALTH TRUST'S JACKSON MEMORIAL HOSPITAL AND RELATED FACILITIES

Date_______________________________

Indicate the fellowship program to which you are applying: _______________________________

1. PERSONAL DATA:

Name in full: _______________________________

First   Middle   Last

Current mailing address: _______________________________

Street   City   State   Zip code

Telephone: ________-____________________   E-mail: _______________________________

Area code

Permanent address if different from current

____

Street   City   State   Zip Code

Place of Birth _______________________________   Date of Birth_______________________

Are you a U.S. citizen? **Yes** _____ **No** _____

If no, current status or visa _______________________________

HIB Visas are no longer accepted.

2. EDUCATION

Medical School _______________________________

Name   Degree

____

Location (City and State)   Date or Expected Date (mm/dd/yyyy)

List chronologically your activities from the time of graduation from Medical School to present. Specify type of post-graduate training, if any.

FROM TO   ACTIVITY   PLACE   DEGREE, IF ANY

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(If additional space is required, please use separate sheet of paper)

3. EXPERIENCE

Special Clinical and/or Research experience ______________________________

Professional practice, location and dates ______________________________

Memberships in professional societies and list any publications ______________________________

(Use separate sheet of paper if needed)

4. MEDICAL LICENSURE AND CERTIFICATION (if applicable)

Date and Results of National Boards Examinations or F.L.E.X. (please include copy of results)

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Attach copies of all State Licenses issued to you.

Have you ever had an application for medical licensure denied? ______________________________.
If so, state the date, circumstances, and State where your application was denied.

Have you ever had a medical license revoked? ______________. If so, state date, circumstances and State where the license was revoked. ______________________________

Since your sixteenth birthday, have you ever been convicted of a felonious offense or are there felony charges currently pending against you? ______________ If so, indicate as to the court involved, nature of offense, disposition or current status of the case and date of case.

5. FOREIGN MEDICAL SCHOOL GRADUATES ONLY

Citizenship and Date ______________________________ (if not U.S. Citizen, type of Visa) ______________________________. If on a J.1 exchange visitor's visa, give country ______________________________. Have you passed your Foreign Medical Graduates Examination in the Medical Sciences (FMGEMS)? ______________________________

Score on Basic Sciences _____ Clinical Sciences _____ English _____ Pass/Fail (Circle one).

Give number and indicate type of certificate ______________ Standard __________ Interim__________

6. A minimum of three letters of Reference is required: (One should be from the Program Director; and two from physicians who have observed you or supervised you in recent training programs. If you have had previous post-graduate training, one letter must be from your former program director).

List below the names of your three references. All correspondence should be sent directly to the Coordinator of Fellowship Programs.

1. ____
   Name Address
2. ____
   Name Address
3. ____
   Name Address

Any Others:

____
Name Address

____
Name Address

7. PLANS AFTER RESIDENCY What are your immediate and long range plans after Residency (i.e. Military Service, residency, specialty, practice, academic medicine, etc.)

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8.AGREEMENT

If I am offered an appointment by the Public Health Trust to serve at the University of Miami/Jackson Memorial Hospital Medical Center and I accept same, I will abide by all the Rules and Regulations of the included Hospitals for members of the House Staff including but not limited to Medical Staff Bylaws, Medical Staff Rules and Regulations , Public Health Trust Policies and Procedures and the Collective Bargaining Agreement between the Public Health Trust and the Committee of Interns and Residents and will to the best of my ability fulfill the obligations of my assignment for the full term of my appointment.

Anticipated Start Date ______________________ Anticipated Ending Date ______________________

9. ENCLOSE THE COMPLETED APPLICATION WITH THE FOLLOWING DOCUMENTS:

- Curriculum Vitae
- Personal Statement
- Photo
- Official Medical School Transcript (a copy is OK)
- Dean's Letter
- Letters of Recommendation
- Copy of Medical School Diploma
- Copy of Internship Diploma
- Copy of Residency Diploma
- Copy of Valid ECFMG Certificate and Scores (if applicable)
- FLEX Scores (if applicable)
- Copy of USMLE Scores OR National Board Scores
- ITE Scores (for Anesthesiology residents)
- COMLEX Scores (if applicable)
- Copy of valid BLS/ACLS Certification
- Copy of Full Florida Medical License (if applicable)
- Copy of J1 Visa/Permanent Resident/Work Permit card

10. "I hereby declare that I have examined this application; and to the best of my knowledge and belief, it is true, correct, and complete."

Signature ____
Applicant

Notary Public ____________________________________

My Commission Expires ________________________ 20___

Seal

Mail entire contents to the Chief or Program Director to:

Maria-Cristina Wells-Albornoz, MHA, MPH
Fellowship Program Coordinator
UM/JMH Department of Anesthesiology
Jackson Memorial Hospital
Ryder Trauma Center (T-215)
1800 NW 10 Avenue (M-820)
Miami, Fl 33136
Documents may also be scanned and sent via e-mail at mcwells@med.miami.edu