

# CHECKLIST FOR PROCESSING HOUSE STAFF APPLICATIONS

\_\_\_\_\_ *Cover letter must include the following*

- the applicant's name, dates of appointment and level requested, and **must be signed by the department Chairman**
- the applicant has been interviewed and evaluated by the members of the department
- the applicant's credentials have been reviewed by the departmental graduate medical education committee and has met departmental and institutional standards of clinical and academic excellence
- the applicant has been recommended for approval by the graduate medical education committee of the department
- indicate source of funding, i.e. hospital, grant, etc.

\_\_\_\_\_ *Copy of ERAS or other matched application with photograph*

\_\_\_\_\_ *Medical School transcript/Dean's letter.*

\_\_\_\_\_ *Three letters of recommendation*

- Dean's letter counts as one of the three letters.
- If the applicant is in a current training program, **one of the letters must be from the current Program Director**.
- House staff who are starting at a PGY 2 level, there must be one **current** letter of recommendation (written within the last 12 months) from an attending during their internship year. (Letters from their 4<sup>th</sup> year of medical school do not fill this requirement.)
- Applicants who have been in practice must provide a letter of recommendation from the chief of staff of the hospital where they are currently practicing or from the county medical or osteopathic society.

\_\_\_\_\_ *A CV is required* for applicants and should **include all activities since graduation from medical school.**

\_\_\_\_\_ *Copies of examination scores:*

Applicants entering as PGY 1 or PGY 2 must have the following:

- USMLE Step 1 and Step 2 (Clinical Knowledge and Clinical Skills)
- OR**
- COMLEX Level 1 and Level 2 (Cognitive Evaluation and Performance Evaluation)

Applicants entering as PGY 3 or above must have the following:

- USMLE Step 1, Step 2 (Clinical Knowledge and Clinical Skills) and Step 3
- OR**
- COMLEX Level 1, Level 2 Cognitive Evaluation and Performance Evaluation and Level 3

National Boards and FLEX are also accepted

\_\_\_\_\_ *Copies of any unrestricted licenses* held by the applicant.

\_\_\_\_\_ *Provide evidence of a Valid Visa* for alien graduates of foreign medical schools.

\_\_\_\_\_ *Copy of the ECFMG certificate* for all graduates of foreign medical schools. A status report is not acceptable.

**THE COMPLETED APPLICATION AND SUPPORTING CREDENTIALS MUST BE SUBMITTED TO THE HOUSE STAFF OFFICE AT LEAST 90 DAYS PRIOR TO THE START OF THE RESIDENT'S OR CLINICAL FELLOW'S TRAINING PROGRAM**



# Application for Graduate Training

PLEASE MOUNT  
PHOTOGRAPH HERE OR  
ELECTRONICALLY ATTACH  
PHOTO

**Instructions:**

1. Type or print legibly
2. Attached required documents
  - current curriculum vitae (include all activities since medical school graduation with month/year format)
  - copy of medical school transcript and/or Dean's Letter
  - copy USMLE or COMLEX scores
  - copy of ECFMG Certificate, if applicable
3. Request letters of recommendation be sent to the program to which you are applying as follows:
  - additional recommendations (Dean's Letter counts as Letter of Recommendation)

<b>Residency or Fellowship Request</b>			
Department		Dates of Proposed Training	
<b>Personal Information</b>			
Name (Last, First, Middle)		MD/DO/DMD/DDS	Gender
Mailing Address (Street)		Telephone Number	Cell Number
(City, State, Zip Code)		E-Mail Address	
Permanent Address (Street)		Telephone Number	
(City, State, Zip Code)			
Social Security Number	Age	Date of Birth (Month/Day/Year)	Place of Birth
U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, citizen of what country?	
Type of Visa on which you have entered/ will enter the United States (Education, Immigrant, Other)			
Educational Commission for Foreign Medical Graduates (ECFMG) Number (Attach copy of certificate)			
Can you perform the essential functions of your residency/fellowship position with or without reasonable accommodation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If No, Please Explain			
Marital Status	Name of Spouse	Address	
If not married, name of nearest next of kin		Address	
Military Status (Dates of Service)			
<b>Undergraduate Education</b>			
(Name, City, State, Country)		Date of Attendance to	Degree
<b>Medical School Education</b>			
(Name, City, State, Country)		Date of Attendance to	Degree

**Current Post Graduate Hospital Training**

<b>First Post Graduate year or Internship Hospital (Name, Address)</b>	
Specialty	Dates of training _____ to _____
Board Credit Year	Program Director

<b>Residency Hospital (Name, Address)</b>	
Type of Residency	Dates of training _____ to _____
Board Credit Years	Program Director

<b>Additional Hospital Training (Name, Address)</b>	
Type of Training	Dates of training _____ to _____
Board Credit Years	Program Director or Chief

<b>Please indicate the exams you have taken:</b> (Please attach copies of exam results)				
<input type="checkbox"/> USMLE, Step 1	<input type="checkbox"/> COMLEX, Step 1	<input type="checkbox"/> NBME, Part 1	<input type="checkbox"/> FLEX I	<input type="checkbox"/> NBDE, Part 1
<input type="checkbox"/> USMLE, Step 2 CK	<input type="checkbox"/> COMLEX, Step 2 CK	<input type="checkbox"/> NBME, Part II	<input type="checkbox"/> FLEX II	<input type="checkbox"/> NBDE, Part 2
<input type="checkbox"/> USMLE, Step 2 CS	<input type="checkbox"/> COMLEX, Step 2 CS	<input type="checkbox"/> NBME, Part III		
<input type="checkbox"/> USMLE, Step 3	<input type="checkbox"/> COMLEX, Step 3			

<b>Pennsylvania Licensure Information</b> (attach copy of license)	
Are you currently licensed in Pennsylvania? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide License Number _____
	If no, do you have a license pending? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what type? <input type="checkbox"/> MT <input type="checkbox"/> MD <input type="checkbox"/> OT <input type="checkbox"/> OS <input type="checkbox"/> DS
Do you belong to a county medical society? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which one? _____
Membership in Honorary/Professional Societies	

<b>Professional References</b> (List below the names and addresses of three professional references, at least one of whom is a medical college faculty reference).			
Name	Title	Years of Acquaintance	Telephone
1.			
Address (Street, City, State, Zip/Postal Code)		Email	
Name	Title	Years of Acquaintance	Telephone
2.			
Address (Street, City, State, Zip/Postal Code)		Email	
Name	Title	Years of Acquaintance	Telephone
3.			
Address (Street, City, State, Zip/Postal Code)		Email	

In signing this application the physician submitting hereby certifies that the information given is true. Appointments are contingent upon the successful completion of the applicant's current year of graduate medical training, the requirements of the Pennsylvania State Board of Medicine and the Thomas Jefferson University Hospital Graduate Medical Education Committee.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date