TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
School *of* Medicine

APPLICATION FOR RESIDENCY/FELLOWSHIP TRAINING

PHOTO
Please attach photograph with your signature on the front surface 2" x 2" (Optional)

Please indicate the program for which you are applying:
Specialty: _____
Subspecialty (if any): _____
From: _____ *to:* _____
(Date) *(Date)*

Post-Graduate Year: _____

PLEASE TYPE FULL INFORMATION AS APPLICABLE (Use additional sheets when necessary)

PERSONAL

Name (Last)	(First)	(Middle)	Phones: Day	Evening
Present Address (Street)	(City)	(State)	(Zip)	
Permanent Address: C/O (Name of person through whom I can always be contacted)		(Street)		
(City)	(State)	(Zip)	(Permanent Phone Number)	
Social Security Number (Optional)	Date of Birth (Optional)	Place of Birth (Optional)		
Do you have a military obligation? If yes, please explain-If discharged from military, type of discharge			VISA Status (if applicable) ☐ PERMANENT ☐ J-1 ☐ Temporary—Specify ☐ Other—Specify	
Shall participate in NRMP Match ☐ YES ☐ NO	NMRP Code (enter "pending" if unknown)	ECFMG Certification (if applicable)		

TRAINING

Premedical Training:		Degree:		Date:
		Degree:		Date:
Medical School:		City:		
Exact Graduation Date:		Degree:	State or Country:	
Residencies or Fellowships:	(Type)	(Hospital)	(Address)	(Date)
	(Type)	(Hospital)	(Address)	(Date)
	(Type)	(Hospital)	(Address)	(Date)

**LETTER(S) FROM PROGRAM DIRECTOR(S) WITH DATES IN PROGRAM(S) AND MONTHS SATISFACTORILY COMPLETED IS REQUIRED

LICENSURE STATUS

Are you presently licensed to practice medicine in the State of Texas? ☐ Yes ☐ No License Number:

Are you currently, or have you been, licensed to practice in any other state? ☐ Yes ☐ No License Number: State:

If yes, do you plan to file for license in Texas by endorsement? ☐ Yes ☐ No If so, when?

PROFESSIONAL LIABILITY

Have there been or are there currently pending any malpractice claims, suits, settlements or arbitration proceedings involving your professional medical practice? ☐ Yes ☐ No

If yes, please provide list and status on separate sheet

DISCIPLINARY ACTIONS

Have any of the following ever been, or are any currently in the process of being investigated, denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? If yes, please provide a full explanation on a separate sheet.

Medical license in any state	☐ Yes	☐ No
Other professional registration/license	☐ Yes	☐ No
DEA/controlled substance registration	☐ Yes	☐ No
Membership on any hospital medical staff	☐ Yes	☐ No
Clinical privileges or prerogatives/rights on any medical staff	☐ Yes	☐ No
Other institution affiliation (e.g. medical school, HMO, etc.)	☐ Yes	☐ No
Professional society membership or fellowship/Board certification	☐ Yes	☐ No
Any other type of professional sanction	☐ Yes	☐ No

Have there been any felony criminal charges or charges of crimes involving moral turpitude brought against you in the last five years? ☐ Yes ☐ No

If yes, please provide full explanation on separate sheet, including the resolution of charges

HEALTH STATUS

Do you have any physical or mental condition, including alcohol or drug dependency, which results in your inability to perform the essential functions of the position and to exercise the clinical privileges requested, with or without reasonable accommodation? ☐ Yes ☐ No

Are you currently in a monitoring or assistance program for alcohol or drug dependency? ☐ Yes ☐ No

Do you currently engage in illegal drug use or illegal use of controlled dangerous substances? ☐ Yes ☐ No

(If yes, please provide full explanation on separate sheet)

REFERENCES

Letters of Reference, in addition to the Dean's Letter, have been requested from the following individuals:

Name and Title	Institution	Address
1.		
2.		
3.		

NOTARIZED COPY OF ORIGINAL MEDICAL SCHOOL DIPLOMA AND/OR OFFICAL TRANSCRIPT IS TO BE RETURNED WITH THIS APPLICATION. **BOTH DOCUMENTS ARE REQUIRED FOR RESIDENCY.**

PLEASE ATTACH PERSONAL STATEMENT AND CURRICULUM VITAE AND RETURN COMPLETED APPLICATION TO:

TTUHSC SOM
Department of _____
3601 4th Street
MS _____
Lubbock, TX 79430

I FULLY UNDERSTAND THAT ANY MISSTATEMENTS IN OR OMISSIONS FROM THIS APPLICATION CONSTITUTE CAUSE FOR DENIAL OF ACCEPTANCE IN OR CAUSE FOR SUMMARY DISMISSAL FROM THE RESIDENCY/FELLOWSHIP TRAINING PROGRAM. ALL INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE TO MY BEST KNOWLEDGE AND BELIEF. I ACKNOWLEDGE THAT TTUHSC HAS THE RIGHT TO REQUEST ADDITIONAL INFORMATION NOT PROVIDED ON THIS APPLICATION, AND I AGREE TO CONFORM TO ALL RULES AND REGULATIONS OF TTUHSC.

___ _____ _____

Signature of Applicant Date

Please continue to the next page, as all four pages need to be completed.

_____

Applicants Name (print in black ink or type)

REQUIREMENTS FOR RESIDENCY
Passage of USMLE 1, passed within the number of attempts required for Texas licensure.

Any other licensing exams taken prior to residency must be passed within the number of attempts required for Texas licensure.

EXAMINATION HISTORY

EXAMINATION	# OF ATTEMPTS	MOST RECENT DATE TAKEN (Mo/Yr)		DATE PASSED (Mo/Yr)	
ECFMG (Basic)					
ECFMG (Clinical)					
ECFMG (English)					
FLEX Component 1					
FLEX Component 2					
Pre-1985 FLEX					
USMLE Step 1					
USMLE Step 2 (CK)					
USMLE Step 2 (CS)					
USMLE Step 3					
NBME Part 1					
NBME Part 2					
NBME Part 3					
NBOME Part 1					
NBOME Part 2					
NBOME Part 3					
SPEX					
LMCC					

State Board Exam

_____
(Name of state)

1. Have you ever been denied the privilege of taking an examination administered by a U.S. state and/or Canadian provincial licensing agency? ☐ Yes ☐No If yes, give full details: _____

_____

2. Have you ever failed any examination or part thereof, including FLEX, SPEX, LMCC, NBOME, USMLE, ECFMG, state licensing agency examination, as required by this state or any other U.S. state and/or Canadian provincial licensing agency? ☐ Yes ☐No If yes, give full details: _____

_____

I, _____ hereby certify under oath that the information is true and correct.

_____
Signature of Applicant

Subscribed and sworn to before me this _____ day of _____, 20_____.

(Notary seal)

_____
(Notary Public)