

2. EDUCATION:

Medical School: _____
Name Degree

Graduation Date: _____ (mm/yyyy)

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

FROM	TO	TRAINING	LOCATION	DEGREE (if any)

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

3. EXPERIENCE:

List in Chronological order:
(Since graduation from medical school)

Memberships in professional societies and list any publications:

4. MEDICAL LICENSURE AND CERTIFICATION (If applicable)

Required: Dates and Results of National Boards Examinations (USMLE and or COMLEX) or other certification. Please include copies.

ATTACH COPIES OF ALL STATE LICENSES ISSUED TO YOU

Have you ever had a Medical License denied, revoked, suspended, or had any other disciplinary action taken by a Medical Licensing Board? _____ Have you had malpractice suits filed against you, regardless of their outcome? _____

DATE	CIRCUMSTANCE	STATE

Have you ever been convicted of a felony? _____ If yes, give details regarding, the court, nature of offense, disposition and date of case:

5. FOREIGN MEDICAL GRADUATES ONLY

Citizenship and Date _____ (If not U. S. Citizen, type of Visa)
_____ if on exchange visitors program, give country
_____. I have a Standard ECFMG Certificate (and Certificate Revalidated if required). Provide copy of Certificate.

6. REFERENCES

A minimum of three ORIGINAL letters of reference are required: (One should be from the Dean of your Medical School, 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 director).

NAME	ADDRESS	PHONE NUMBER

Additional References

NAME	ADDRESS	PHONE NUMBER

7. AGREEMENT:

If offered an appointment to the Palm Beach County Health Department Preventive Medicine Residency Program and I accept same, I will abide by all the Rules and Regulations of the Residency Program and will fulfill the obligations of my assignment for the full term of my appointment. By my signature on this application, I agree that the listed references, employment history, and educational experiences may be contacted.

8. ENCLOSE WITH THE COMPLETED APPLICATION THE FOLLOWING:

- a) Transcript of Medical School Scholastic Record
- b) Copy of State Licenses
- c) ECFMG Certificate (for Foreign Medical Graduates)
- d) A recent photograph (optional)
- e) A personal statement
- f) Original reference letters should be sent directly to the residency office from the source

9. "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
Graduate Medical Education and Residency Program for
Preventive Medicine/Public Health
Palm Beach County Health Department
P. O. Box 29
West Palm Beach, FL 33402**