

**PALM BEACH COUNTY HEALTH DEPARTMENT
 PREVENTIVE MEDICINE/PUBLIC HEALTH RESIDENCY PROGRAM
 APPLICATION**

Date:

1. PERSONAL DATA:

Name in full:
 Last First Middle

Current mailing address:
 Street
 City State Zip Code

Telephone: () Area Code **E-mail address:**

Permanent address if different from current:
 Street
 City State Zip Code

In Case of an Emergency, nearest relative (not Spouse):
Relationship:
Address:
 Street City State Zip Code
Telephone: () Area Code

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-graduation 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 suites 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 dates 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). Please provide copy of Certificate with this application

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

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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**