

APPLICATION FOR ADMISSION TO GRADUATE MEDICAL EDUCATION UNIVERSITY OF KANSAS MEDICAL CENTER

KUMC is an AA/EO Title IX Institution. For disability accommodations in the application process, contact the EOO Office at 913-588-1206 (voice 913-588-7963 (TDD)).

This publication is available in alternate formats upon request to the Equal Opportunity Office at 913-588-1206.

FOR OTR ONLY	
ENTERED FROM KUMC	
Student Number _____	School /Level _____
Year/Term _____	Residency _____
Date Entered _____	Initials _____

Name _____
 (First) (Middle) (Last) (Maiden If Applicable) Date of Birth _____

Present Address _____
 (Number and Street) (City) (State) (Zip Code) (_____) _____
 (Phone No.)

Permanent Address _____
 (Number and Street) (City) (State) (Zip Code) (_____) _____
 (Phone)

 In order to comply with federal regulations under titles VI and IX of the Civil Rights Act, the University **must** collect data on the race and sex of it's applicants. This information will be used for reporting purposes only. **If you choose to do so**, please check the appropriate boxes:

Female Male American Indian or Alaskan Native Asian or Pacific Islander Black Hispanic White Other
 Social Security No. _____ Marital Status _____

Country of Birth _____ Citizenship _____

Proposed Program → → → Intern _____ Resident _____ Fellow _____
 (Specific Internship) (Specialty) (Specialty)

Request appointment to begin on _____, 20____. My letter of application, which outlines my academic Objectives, is attached. My picture is attached to the outline. Transcripts are (attached), (being sent separately).

"Social security number and student status data may be provided to other state agencies for use in detection of fraudulent or illegal claims against State monies."

United States Medical Licensing Examination:
 Part I _____ Yes No Part II _____ Yes No Part III _____ Yes No
 (Date) Passed (Date) Passed (Date) Passed

States in which you are licensed to practice _____

FOREIGN MEDICAL SCHOOL GRADUATES-Complete the following:
 My U.S. Training originally began on (mm/dd/yyyy) _____. Type of Visa _____ Visa Number _____
 Copies of the following evidence of qualifications are attached: _____ Interim _____ Standard ECFMG Cert. # _____
 _____ TOEFL Examination passed; U.S. State License (specify) _____ Certified by American Specialty Board (specify) _____

ACADEMIC AND PROFESSIONAL EXPERIENCE RECORD

(Name of high school from which graduated)	(Location – City and State)	(Date Graduated)
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Prior attendance at the University of Kansas: Yes No Dates: ____ to ____.
 Education and Training:

Name & Location of College, University, Hospital, Training Institution & Previous Residencies	Attendance (Years)	Degree or Certificate	Major Program	Completed Program	Date Awarded
_____	_____ to _____	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
_____	_____ to _____	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
_____	_____ to _____	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
_____	_____ to _____	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
_____	_____ to _____	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____

REFERENCES: List the name, position, and address of three or more persons who are acquainted with your academic and professional experience and from whom **you** will request confidential statements in support of your application.

Past and present relationship to Armed Services _____
 What scholarships or other academic awards have you received ? _____

I hereby authorize the institutions listed above to disclose to the University of Kansas School of Medicine any and all records which pertain to education or residency training in which I have participated and to furnish copies of all such records to the University of Kansas School of Medicine. I hereby release all such institutions from any liability arising from or which might arise from the furnishing of the information requested.

Date of Application _____ Signature of Applicant _____

DEPARTMENT ACTION

The Department of _____ accepts the above named as a/an _____ in the
 Following Specialty: _____. Accepted as: PGY1, PGY2, PGY3, PGY4, PGY5, PGY6. Official entry date _____
 Date: _____ Signature of Departmental Representative _____