University of Florida, College of Medicine
Required Application for Off-Cycle (non-MATCH)
Residents / Fellows and non-ACGME (non-standard) Training Programs

RESET FORM

Basic Information

First Name*
Middle Name
Last Name*
Suffix
Sex*
Email*
Birth Date*
I authorize the release of my birth date to programs ☐

Previous Last Name
Preferred Name
Preferred Phone*
Mobile Phone
Alternate Phone

Race/Ethnicity (Optional)

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- Other: _____

Current Mailing Address

Address 1*
Address 2
Country*
State
City*
Postal Code

Is your permanent address the same as your current mailing address*
Yes ☐ No ☐

Permanent Address

Address 1
Address 2
Country
State
City
Postal Code
Phone

Work Authorization

Are you currently authorized to work in the United States as a US Citizen or Green-card Holder?* ☐ Yes ☐ No

If the answer to the above is "No", what is your current work authorization?*

Will you need visa sponsorship through ECFMG (J-1) or the teaching hospital (H-1B) to complete the entirety of your GME training?*

☐ Yes ☐ No

If yes, please select the visa(s) for which you will seek sponsorship. Select all that apply.*

☐ H-1B ☐ J-1

*Eligibility for ECFMG J-1 visa sponsorship is not to be presumed. For details on ECFMG J-1 requirements and restrictions, please visit http://www.ecfmg.org/evsp/requirements.html.

*Eligibility for H-1B sponsorship is not to be presumed. Sponsorship will be determined by each department.

If you currently reside in the United States or Canada, please identify your current state or province of residence.

Additional Information

USMLE/ECFMG ID:

NBOME ID: *(Required for D.O. applicants)*

AOA Member Number:

I am ACLS (Advanced Cardiovascular Life Support) certified in the U.S.: ☐ Yes ☐ No

If yes, ACLS expiration date:

I am PALS (Pediatric Advanced Life Support) certified in the U.S.: ☐ Yes ☐ No

If yes, PALS expiration date:

I am BLS (Basic Life Support) certified in the U.S.: ☐ Yes ☐ No

If yes, BLS expiration date:

Sigma Sigma Phi Status:

Alpha Omega Alpha Status:

Gold Humanism Honor Society Status:

Military Information

Are you committed to fulfill a U.S. military active-duty service obligation/deferment? * ☐ Yes ☐ No

If yes, number of years remaining: Branch:

Do you have any other service obligations (e.g., military reserves, public health/state programs, etc.)?* ☐ Yes ☐ No

If yes, describe:

Additional Information

Hobbies and Interests:

Hometown(s):

Education

Higher Education

This section allows multiple entries for each undergraduate and graduate school you have attached.

Since most non-U.S. educational systems do not follow the U.S. model, almost all students and graduates of international medical schools will indicate "None."

None ☐

Entry 1

Institution* Location*

Education Type* Field of Study*

Degree Expected or Earned*

If Yes: Degree Month Year

Dates of Attendance: From Month* From Year* To Month* To Year*

Entry 2

Institution* Location*

Education Type* Field of Study*

Degree Expected or Earned*

If Yes: Degree Month Year

Dates of Attendance: From Month* From Year* To Month* To Year*

Medical Education

This section allows entries for each medical school you have attended.

Entry 1

Country*

Institution*

Degree*

Degree Month*

Degree Year*

Dates of Education

From Month* From Year* To Month* To Year*

Entry 2

Country*

Institution*

Degree*

Degree Month*

Degree Year*

Dates of Education

From Month* From Year* To Month* To Year*

Additional Information

Membership in Honorary/Professional Societies:

Medical School Awards:

Other Awards/ Accomplishments:

Experience

Training

Please add an entry for any current or prior AOA Internship, AOA Residency, AOA Fellowship, ACGME Residency, or ACGME/RCPSC/UCNS Fellowship in which you have trained, regardless of the length of time spent in the training. Save the file after completing the required fields. Additional entries may be added as needed.

☐ None

Entry 1

Type of Training*

Specialty*

Institution/Program*

Country*

State/Province

City*

Program Director*

Supervisor*

Dates of Residency/Fellowship:

From Month* From Year* To Month* To Year*

Reason for Leaving:

Entry 2

Type of Training*

Specialty*

Institution/Program*

Country*

State/Province

City*

Program Director*

Supervisor*

Dates of Residency/Fellowship:

From Month* From Year* To Month* To Year*

Reason for Leaving:

Additional Information

Was your medical education/training extended or interrupted?* ☐ Yes ☐ No

If yes, please provide details or attachment

Have you ever been on academic probation, remediation, or held back from an education/training program? ☐ Yes ☐ No

If yes, please provide details or attachment

Has your employment ever been involuntary terminated or have you resigned in lieu of termination? Yes ☐ No ☐

If yes, please provide details or attachment

Have you ever been on Administrative Leave from your program for investigations in relations to disciplinary, professionalism and medical practices? Yes ☐ No ☐
If yes, please provide details

If yes, please provide details or attachment

Licensure

Please add an entry for any of your state medical licenses.

☐ None

Entry 1

State*

License Type*

License Number*

Expiration Month*

Expiration Year*

Entry 2

State*

License Type*

License Number*

Expiration Month*

Expiration Year*

Additional Information

Has your medical license ever been suspended/revoked/voluntarily terminated?* ☐ Yes ☐ No

If yes, Please provide details

Have you been named in a malpractice case?* ☐ Yes ☐ No

If yes, Please provide details,

Do you have a physical, medical (including substance abuse), mental or emotional condition that could affect your ability to exercise the clinical privileges reqested safely and competently? ☐ Yes ☐ No

If yes, please explain or provide attachment:

Have you ever been convicted of a misdemeanor in the United States?* ☐ Yes ☐ No

If yes, please explain or provide attachment:

Have you ever been convicted of a felony in the United States?* ☐ Yes ☐ No

If yes, please explain or provide attachment:

Are you able to carry out the responsibilities of a resident, intern, or a fellow in the specialties and at the specific training programs to which you are applying, including the functional requirements, cognitive requirements, and interpersonal and communication requirements with or without reasonable accommodations?*

Yes ☐ No ☐ No Response ☐

Are you Board Certified?* ☐ Yes ☐ No

If yes, Board Name:

DEA Registration Number:

Expiration Month: Expiration Year:

Certification

I certify that the information contained within the application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position; may result in an investigation by the University of Florida, College of Medicine, or if employed, may constitute cause for termination from the program.

Use and Dissemination of Resident, Intern, Fellow, and Residency, Internship, and Fellowship Application Data and to the University of Florida, College of Medicine's collection and other processing of my personal data according to University of Florida privacy policies.

Signature Date