

ST. JOHN'S EPISCOPAL HOSPITAL  
327 BEACH 19TH STREET  
FAR ROCKAWAY, NEW YORK 11691

DEPARTMENT OF INTERNAL MEDICINE  
MEDICAL RESIDENCY TRAINING PROGRAM APPLICATION

I. APPLICATION FOR: PGY I [ ] PGY II [ ] PGY III [ ]  
NRMP Match Participant: YES [ ] NO [ ] NRMP#: \_\_\_\_\_

NAME \_\_\_\_\_  
LAST FIRST MIDDLE

ADDRESS \_\_\_\_\_  
STREET CITY STATE/ZIP

PHONE (\_\_\_\_) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX: M [ ] F [ ]

E-MAIL ADDRESS: \_\_\_\_\_

MARRIED OR SINGLE \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

CITIZENSHIP: U.S. [ ] OTHER: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

IF APPLICABLE: VISA STATUS: PERMANENT \_\_\_\_\_ TEMPORARY (specify) \_\_\_\_\_

II. COLLEGE \_\_\_\_\_ DEGREE \_\_\_\_\_ MTH/YR \_\_\_\_\_ MAJOR \_\_\_\_\_

GRADUATE SCHOOL \_\_\_\_\_ DEGREE \_\_\_\_\_ MTH/YR \_\_\_\_\_ MAJOR \_\_\_\_\_

MEDICAL SCHOOL \_\_\_\_\_ DEGREE \_\_\_\_\_ MTH/YR \_\_\_\_\_ MAJOR \_\_\_\_\_

LICENSE: STATE(S) \_\_\_\_\_ YEAR(S) \_\_\_\_\_ NUMBER(S) \_\_\_\_\_

U.S.M.L.E. STEP 1 SCORE \_\_\_\_\_ # OF ATTEMPTS \_\_\_\_\_ DATE PASSED \_\_\_\_\_  
STEP 2 SCORE \_\_\_\_\_ # OF ATTEMPTS \_\_\_\_\_ DATE PASSED \_\_\_\_\_  
STEP 3 SCORE \_\_\_\_\_ # OF ATTEMPTS \_\_\_\_\_ DATE PASSED \_\_\_\_\_

NATIONAL BOARDS PART 1 SCORE \_\_\_\_\_ # OF ATTEMPTS \_\_\_\_\_ DATE PASSED \_\_\_\_\_  
PART 2 SCORE \_\_\_\_\_ # OF ATTEMPTS \_\_\_\_\_ DATE PASSED \_\_\_\_\_  
PART 3 SCORE \_\_\_\_\_ # OF ATTEMPTS \_\_\_\_\_ DATE PASSED \_\_\_\_\_

FMGEM BASIC SCIENCE  
# \_\_\_\_\_ SCORE \_\_\_\_\_ # OF ATTEMPTS \_\_\_\_\_ DATE PASSED \_\_\_\_\_

CLINICAL SCIENCE  
SCORE \_\_\_\_\_ # OF ATTEMPTS \_\_\_\_\_ DATE PASSED \_\_\_\_\_

ECFMG  
# \_\_\_\_\_ SCORE \_\_\_\_\_ # OF ATTEMPTS \_\_\_\_\_ DATE PASSED \_\_\_\_\_

FLEX # \_\_\_\_\_ STEP 1 SCORE \_\_\_\_\_ # OF ATTEMPTS \_\_\_\_\_ DATE PASSED \_\_\_\_\_  
STEP 2 SCORE \_\_\_\_\_ # OF ATTEMPTS \_\_\_\_\_ DATE PASSED \_\_\_\_\_

FIFTH PATHWAY DIPLOMA \_\_\_\_\_ DATE OF COMPLETION \_\_\_\_\_

III. DOCUMENTS AND REFERENCES: (Necessary for application to be considered)

1. TRANSCRIPT OF MEDICAL SCHOOL RECORDS (must be mailed to hospital directly from school)
2. TWO LETTERS OF RECOMMENDATION.
3. LETTER FROM DEAN OF MEDICAL SCHOOL.
4. DOCUMENTATION OF SCORES ON EXAMS ABOVE.
5. ECFMG CERTIFICATE.
6. CERTIFIED TRANSLATION OF MEDICAL SCHOOL RECORDS AND DIPLOMA.
7. FIFTH PATHWAY DIPLOMA (with certified translation).



**EPISCOPAL HEALTH SERVICES, INC.**

**NOTICE TO APPLICANTS**

**CONSENT TO DRUG SCREENING/RELEASE OF INFORMATION**

In accordance with Episcopal Health Services' Health and Safety Policy concerning drugs in the work place, I \_\_\_\_\_, hereby consent to undergo a drug screening test as part of a pre-employment examination. The results of the testing will be released only to Episcopal Health Services, Inc. I acknowledge receipt of all required information regarding off site drug testing centers.

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**EPISCOPAL HEALTH SERVICES, INC.**

**Notice to Applicant**

In order to provide the best possible care to all of our clients and to maintain a drug free workplace, Episcopal Health Services will include drug screening as part of the pre-employment process. ***A positive drug screening will be considered a failure to pass the pre-employment process and further consideration will be denied.*** We hope you will support us at Episcopal Health Services Inc. in our mission to provide the very best quality in patient care.

\_\_\_\_\_  
Director of Human Resources

\_\_\_\_\_  
Date

---

**Applicant Statement and Release**

If I am offered employment with Episcopal Health Services, that offer will be contingent upon my successful completion of the pre-employment drug screening. During the process, I will be asked to provide a freshly voided urine specimen. In order to protect my privacy and to ensure confidentiality, all specimens will be identified by number and not by name. In the event of my failure to have a pre-employment physical and/or drug screening at the time scheduled, I understand it will result in my **not** being considered for employment at Episcopal Health Services Inc. (I may reapply after one year).

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date