St. John's Episcopal Hospital

APPLICATION FOR FAMILY PRACTICE RESIDENCY PROGRAM

NAME _____ **SS#**_____**DATE OF BIRTH**_____ ____
LAST FIRST
ADDRESS_____ ____
HOME PHONE _____ **MESSAGE PHONE**_____**MALE** _____**FEMALE**_____
MARITAL STATUS _____

_____

HIGH SCHOOL _____ **GRADUATION DATE** _____
COLLEGE _____ **GRADUATION DATE** _____
MEDICAL SCHOOL _____ **GRADUATION DATE** _____
NATIONAL BOARDS: PART TAKE **DATE** _____

EXTERNSHIPS
HOSPITAL AND ADDRESS **FROM** **TO** **TYPE**_____

_____
_____
_____

INTERNSHIP: HOSPITAL AND ADDRESS _____
_____
_____

PREVIOUS EMPLOYMENT (List Latest Position First)

FROM **TO** **NAME OF EMPLOYER** **ADDRESS** **POSITION**

_____
_____
_____

LIST 3 REFERENCES TO BE CONTACTED

_____
_____
_____

THE FOLLOWING MUST ACCOMPANY APPLICATION: Two letters of recommendation
Medical School Transcript
Board Scores

IF NOT A CITIZEN OF THE UNITED STATES, DO YOU HAVE THE RIGHT TO REMAIN PERMANENTLY AND WORK IN UNITED STATES _____

IMMIGRATION STATUS _____

I understand and agree, if appointed by St. John's Episcopal Hospital, South Shore to faithfully perform in all respects all of the duties assigned to me, and to observe all the rules and regulations of the Hospital and American Osteopathic Association as now, and which will hereafter be established, and that I will faithfully serve for the duration of the term for which I am appointed. I understand that my services must be wholly satisfactory to the Hospital and its decision shall at all times be final as to continuance or termination of my services at the Hospital.

I agree to physical and medical examinations at any time at the option of the Hospital, at no personal expense, and agree that examining physician may disclose to the Hospital or its representatives the results of such examination. I give permission to contact all or any previous references for full information.

Further, I understand that as a Resident at St. John's Episcopal Hospital, South Shore, I will have Federal and State taxes and Social Security payments withheld from my check. I further understand that I will receive fringe benefits: namely work compensation, New York State Disability, Blue Cross, Blue Shield Major Medical and Dental benefits for myself.

All of the foregoing information I have supplied in this application is a full and complete statement of the facts and it is understood that if any falsification be discovered, it will constitute grounds for dismissal upon discovery thereof.

SIGNED **DATE:** _____

_____

_____

ACTION ON FAMILY PRACTICE RESIDENCY APPLICATION

DATE INTERVIEWED _____ **INTERVIEWED BY:** _____
RECOMMENDATION:

_____

_____

_____

MEDICAL EDUCATION COMMITTEE
FINAL ACTION _____

_____

_____
DIRECTOR OF MEDICAL EDUCATION