BAYLOR COLLEGE OF MEDICINE HOUSE STAFF APPLICATION

Michael E. DeBakey Department of Surgery
Surgery Education Office
One Baylor Plaza, Suite 404D
Houston, Texas 77030
(713) 798-6078

Optionally, provide a small passport style photograph in this space.

If applicable, are you registered with the National Resident Matching Program? ________

Application for house staff appointment in (specialty):	Level of training applied for:	Beginning (MO)(DY)(YR):

Name: Last First Middle		Present Address:	
Telephone (Home)		Telephone (Hospital/School)	Social Security Number
Permanent home address		Name and address of someone always able to contact you	
Birth date (MO)(DAY)(YR)	Place of Birth	Citizenship	If non-citizen, date of entry into U.S.
If non-citizen, type of Visa held (Exchange Visitor, Immigrant, etc.)			
Do you have any condition that might impair your participation in the program? If so, please describe.			

EDUCATION:

High School	Name	From	To	
	Address			
College		From	To	Degree
		From	To	Degree
Medical School	Name	From	To	Degree
	Address			
	Name	From	To	Degree
	Address			

If a graduate of a foreign medical school, have you obtained certification from the Educational commission for Foreign Medical Gradates? _____ Indicate exams passed: ECFMG ____, Visa Qualifying Examination (VQE) ____, Foreign Medical Graduate Exam in the Medical Sciences (FMGEMS) ____, National Board Exam (parts 1-2-3) ____, United States Medical Licensing Examination (USMLE) (steps 1-2-3) ____, or FLEX ____. Please enclose notarized copies of your exam results and ECFMG certificate.

Internship,	Hospital	From	To	Field
		City and State		
Residency	Hospital	From	To	Field
		City and State		
and	Hospital	From	To	Field
		City and State		
Fellowship	Hospital	From	To	Field
		City and State		
Graduate School	College(s)	From	To	Degree
	Field(s)			

Membership in Honorary or Professional Societies, prizes, awards, fellowships, etc. Please include AOA membership

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PROFESSIONAL GOALS AND CAREER PLANS (Omit if included in CV or Personal Statement.)

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U.S. Board certification or eligibility	Specialty	Certified or Eligible (circle one)	Date of Certification
	Specialty	Certified or Eligible (circle one)	Date of Certification

MEDICAL LICENSURE:	State ____________	Year Issued ________
	State ____________	Year Issued ________

Faculty Appointments	College	From	To
	Department	Rank	
	College	From	To
	Department	Rank	

Practice or other clinical experiences	Location	From	To
	Type		
	Location	From	To
	Type		

PUBLICATIONS: If applicable, please list publications on a separate sheet.

TRANSCRIPT: Please request the Registrar of your Medical College to send a transcript directly to the address at the top of the first page.

REFERENCES: Please list four references, of whom one must be the Dean of Students at your Medical College and three must be physicians who can render an evaluation of your professional and academic abilities. Please ask that your recommenders comment on academic and personal attributes such as judgment, industry, interpersonal relationships, capacity to assume responsibility and professional ethics. Please have these recommendations sent directly to the address at the top of the first page.

Dean of Students	Address
Other Recommenders	Address

I certify that to the best of my knowledge, the above information is accurate and correct

Date ____________________ Signature ______________________________