



**LOYOLA
UNIVERSITY
CHICAGO**

Graduate Medical & Dental Education Residency Application
Foster G. McGaw Hospital and Loyola University Health System
 2160 South First Avenue
 Maywood, IL 60153

PLEASE PRINT LEGIBLY

I. PERSONAL SECTION					
APPLICANT NAME LAST FIRST MIDDLE			SOCIAL SECURITY NUMBER		
CURRENT ADDRESS STREET		CITY	STATE	ZIPCODE	TELEPHONE
PERMANENT ADDRESS (if different from above) STREET		CITY	STATE	ZIPCODE	TELEPHONE
BIRTH DATE	SEX (CIRCLE ONE) MALE FEMALE	BIRTH PLACE		MARITAL STATUS:	
CITIZENSHIP		VISA STATUS		SPOUSE NAME:	
RACE (OPTIONAL)		RELIGION (OPTIONAL)		NRMP NUMBER :	
LOYOLA RESIDENCY/FELLOWSHIP PROGRAM (SPECIALTY)				LOYOLA START DATE:	
				LOYOLA COMPLETION DATE:	
				LOYOLA PGY LEVEL:	

II. EDUCATION SECTION - LIST ALL COLLEGES, UNIVERSITIES OR MEDICAL SCHOOL YOU HAVE ATTENDED					
	SCHOOL	LOCATION (CITY, STATE)	DATES OF ATTENDANCE		DEGREE EARNED
			From (Month/Year)	To (Month/Year)	
Undergraduate					
Medical or Dental School					
Graduate School					

III. PROFESSIONAL SECTION			
ILLINOIS LICENSURE - LICENSE NUMBER :		DATE EXPIRES:	
OTHER STATE LICENSURE:	STATE:	NUMBER:	STATUS:
OTHER STATE LICENSURE:	STATE:	NUMBER:	STATUS:

BOARD CERTIFICATION: if applicable	
specialty: _____ Are you board certified in your primary specialty? ___ Yes ___ No	If "yes", name of certifying board _____ -

If "no", have you taken the specialty boards? ___Yes ___No Are you scheduled to take the specialty boards? ___Yes ___No Have you ever taken the specialty boards and failed? ___Yes ___No Number of years from present date required for eligibility _____ Date Specialty Board taken (awaiting score) _____ Date scheduled to take Specialty Board _____	certificate number _____ date certified (MM/DD/YYYY) _____ date certification expires (MM/DD/YYYY) _____ date recertified (if applicable) _____
Secondary specialty, subspecialty or added qualification _____ Are you board certified in your specialty or subspecialty? ___ Yes ___ No	If "yes", name of certifying board _____ _____ certificate number _____ date certified (MM/DD/YYYY) _____ date certification expires (MM/DD/YYYY) _____ date recertified (if applicable) _____
If "no", have you taken the specialty boards? ___Yes ___No Are you scheduled to take the specialty boards? ___Yes ___No Have you ever taken the specialty boards and failed? ___Yes ___No Number of years from present date required for eligibility _____ Date Specialty Board taken (awaiting score) _____ Date scheduled to take Specialty Board _____	certificate number _____ date certified (MM/DD/YYYY) _____ date certification expires (MM/DD/YYYY) _____ date recertified (if applicable) _____

USMLE /COMPLEX/FMGEMS - RECORD OF EXAMINATION: Each examination attempt must be listed, regardless of whether you passed, failed, or were absent. (If additional space is needed, attach a separate sheet).

NAME OF EXAMINATION	STATE	MONTH/YEAR	SCORES		RESULTS
			3-Digit	2-Digit	
					Results (Passed, Failed, Absent)

FOREIGN MEDICAL GRADUATE: (PLEASE ATTACH A COPY OF CERTIFICATE)

ECFMG CERTIFICATE #: _____	CERTIFICATE EXPIRATION DATE: _____
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WORK HISTORY (SINCE GRADUATION FROM MEDICAL SCHOOL) [INCLUDE RESIDENCIES, UNEMPLOYMENT, VACATION, ETC]. IF ADDITIONAL SPACE IS NEEDED, ATTACH A SEPARATE SHEET.

Institution Name/City State	DATES OF EMPLOYMENT/ATTENDANCE		SUPERVISOR NAME
	From (Month/Year)	To (Month/Year)	
Internship/Residency/Fellowship (circle one). Specialty: _____			
Institution Name/City State	DATES OF EMPLOYMENT/ATTENDANCE		SUPERVISOR NAME
	From (Month/Year)	To (Month/Year)	
Internship/Residency/Fellowship (circle one). Specialty: _____			

Institution Name/City State Internship/Residency/Fellowship (circle one). Specialty: _____	From (Month/Year)	To (Month/Year)	SUPERVISOR NAME
Institution Name/City State Internship/Residency/Fellowship (circle one). Specialty: _____	From (Month/Year)	To (Month/Year)	SUPERVISOR NAME
Institution Name/City State Internship/Residency/Fellowship (circle one). Specialty: _____	From (Month/Year)	To (Month/Year)	SUPERVISOR NAME
Institution Name/City State Internship/Residency/Fellowship (circle one). Specialty: _____	From (Month/Year)	To (Month/Year)	SUPERVISOR NAME

PERSONAL HISTORY INFORMATION (THIS PART <u>MUST</u> BE COMPLETED BY ALL APPLICANTS)	YES	NO
Have you ever been convicted of any criminal offense including any related to health care fraud, in any state or in federal court (other than minor traffic violations)?		
Have you ever been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere?		
Have you ever been subject to governmental agency, medical or professional society disciplinary proceedings resulting in reprimand, censure, sanction or modification of your practice, or are you currently the subject of an administrative proceeding or review by any such agency or society?		
Are you currently or have you ever been excluded, debarred, sanctioned or otherwise declared ineligible for participation in a federal or state healthcare program?		
Has your membership in any medical society or professional organization ever been denied, suspended, revoked or voluntarily surrendered in lieu of disciplinary action?		
Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position?		
If you answered "YES" to any of the questions listed above, please describe each incident in detail on a separate sheet of paper.		

I certify that all information in this application is true and no material omissions have been made. I further understand that any incorrect or incomplete information may be cause for immediate dismissal.

Signature: _____ Date: _____

**DIRECT INQUIRIES AND RETURN THIS APPLICATION TO: RESIDENCY TRAINING PROGRAM
DEPARTMENT OF PATHOLOGY
BLDG. 103, ROOM 0177
LOYOLA UNIVERSITY MEDICAL CENTER**

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MAYWOOD, IL 60153