APPLICATION FOR GRADUATE MEDICAL EDUCATION

LOMA LINDA UNIVERSITY HEALTH
EDUCATION CONSORTIUM

Instructions:

a. TYPE or PRINT IN BLACK INK.
b. Complete ALL questions (incomplete application will be returned). Mark "N/A" if not applicable. Do not simply refer to C.V.
c. Give current and complete addresses. Dates must include month/day/year.
d. Attach a separate sheet if additional space is required.
e. See last page for Required Documentation.

PERSONAL DATA

NAME (Last First Middle)	DATE OF APPLICATION TELEPHONE NUMBER (Include Area Code) RESIDENCE	BUSINESS
PRESENT ADDRESS (Street, City, State, Zip Code)	Place of Birth: City/ State	Country
E-MAIL ADDRESS	DO YOU HAVE THE LEGAL RIGHT TO WORK IN THE UNITED STATES? If "YES", please state on what basis. ☐ NO ☐ YES on what basis:	

APPLICATION INFORMATION

APPLYING FOR TRAINING IN SPECIALTY OF:	PGY-LEVEL	DESIRED START DATE

EXAMINATION INFORMATION

LIST EXAM DATE AND SCORE FOR ANY EXAMINATION ALREADY TAKEN: (Copies of scores for all exams must be submitted to the training program)

USMLE-STEP 1 DATE SCORE	USMLE-STEP 2 DATE SCORE	USMLE-STEP 3 DATE SCORE	OTHER EXAM(S) i.e. NBME, FLEX, etc. List type of exam, date and score

REMARKS:

MEDICAL / DENTAL SCHOOL(S) ATTENDED

NAME OF SCHOOL	ADDRESS OF SCHOOL (City, State, Zip Code)	(ANTICIPATED) GRADUATION (DATE) (Inclusive Dates-begin/end, month/day/yr.)	DEGREE
NAME OF SCHOOL	ADDRESS OF SCHOOL (City, State, Zip Code)	(ANTICIPATED) GRADUATION (DATE) (Inclusive Dates-begin/end, month/day/yr.)	DEGREE

PREVIOUS U.S OR CANADIAN RESIDENCY OR FELLOWSHIP TRAINING

NAME OF HOSPITAL, ADDRESS (City, State, Zip Code) AND PROGRAM DIRECTOR'S NAME	SPECIALTY	TRAINING DATES BEGIN month/day/yr.	 END month/day/yr.	# MONTHS COMPLETED

LICENSURE AND DRUG ENFORCEMENT ADMINISTRATION (DEA) CERTIFICATION

A. CALIFORNIA MEDICAL LICENSE # / EXPIRATION DATE (if License is pending, date submitted)	DEA REGISTRATION # / EXPIRATION DATE

B. LIST OTHER STATES / TERRITORIES IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED
STATE / TERRITORY LICENSE # REGISTRATION CURRENT? If not, explain on separate sheet)

1.

2.

3.

4.

ALL APPLICANTS-CIRCLE APPROPRIATE ANSWER. IF "YES", EXPLAIN DETAILS ON SEPARATE SHEET.

		YES	NO
1.	Has any action, including any investigation, ever been undertaken, whether still pending or completed, which involves denial, revocation, suspension, reduction, limitation, probation, nonrenewal or voluntary relinquishment by resignation or expiration (including relinquishment that was requested or bargained for) of your:		
	a. Medical staff membership or privileges at any hospital, clinic, or other health care facility?	☐	☐
	b. Status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	☐	☐
	c. Specialty board certification?	☐	☐
2.	Have any professional liability claims been filed against you, have you reported any malpractice claim to your insurance carrier, or have you received any letters of intent to sue?	☐	☐
3.	Has any judgment been entered against you in any professional liability case in which you or your professional liability insurance carrier had to or agreed to make a monetary payment?	☐	☐
4.	Has any professional liability insurance carrier ever denied, canceled, refused to renew your policy or placed limitations on the scope of coverage?	☐	☐
5.	Have you ever had any medical license revoked, suspended, denied, restricted, limited or issued/placed in a probational status or voluntarily relinquished?	☐	☐
6.	Have you ever had a DEA certificate revoked, suspended, limited, restricted in any way or voluntarily relinquished?	☐	☐
7.	Within the last five years have you been discharged from any position for any reason?	☐	☐
8.	Within the last five years have you resigned or retired from a position after being notified you would be disciplined or discharged, or after questions about your clinical competence were raised?	☐	☐
9.	Has any action, including any investigation, been undertaken, whether still pending or completed, against you by any governmental, administrative, or law enforcement agency or body, for your alleged failure to comply with laws, statutes, regulations, or any other legal requirements which may be applicable in any way to the practice of your profession or to your rendition of service to patients?	☐	☐
10.	Have you ever been convicted of any crime other than a minor traffic violation(s)? If you answer "YES" give full details including location, dates and type of conviction on an additional page.	☐	☐
11.	Is there anything that would prevent you from performing the essential functions as a resident or fellow in our training program?	☐	☐

TO BE COMPLETED BY APPLICANTS WITH PRIOR PRACTICE EXPERIENCE OR MEDICAL STAFF PRIVILEGES

A. MEDICAL STAFF MEMBERSHIP/PRIVILEGES: List all hospitals, clinics and other health care facilities where you currently have, or have had, medical staff membership and/or clinical privileges or have provided clinical services on some other basis. Please give complete addresses.

1.	Facility		Address (Street, City, State, Zip Code)
	Inclusive Dates (Month/Day/Year)	Status or Position	Telephone and/or FAX#
2.	Facility		Address (Street, City, State, Zip Code)
	Inclusive Dates (Month/Day/Year)	Status or Position	Telephone and/or FAX#

B. PREVIOUS PRACTICE: List all previous practices not otherwise listed on this application, including office, clinic and military. Begin with most recent practice, list others in reverse chronological order.

1.	Name of Practice		Address (Street, City, State, Zip Code)
	Inclusive Dates (Month/day/Year)		Telephone and/or FAX #
2.	Name of Practice		Address (Street, City, State, Zip Code)
	Inclusive Dates (Month/day/Year)		Telephone and/or FAX #

C. PROFESSIONAL LIABILITY INSURANCE:

Current Insurance Carrier		Address (Street, City, State, Zip Code)
Expiration Date (Month/Day/Year)	Policy Number	Telephone and/or FAX#

I declare under penalty of perjury that the information contained in this APPLICATION FOR GRADUATE MEDICAL EDUCATION, curriculum vitae, and personal statement submitted with this Application, is true, correct and complete. If I am accepted into the training program at Loma Linda University Health (LLUH), I understand and agree that submission of any misleading or false information, or any misrepresentation or fraudulent information will subject me to suspension and/or termination whenever the information is discovered.

I authorize all persons, institutions, and entities, including any previous employer(s), school(s) I attended, or organizations for which I volunteered, to provide LLUH, as a prospective employer for purposes of graduate medical education training, and the Graduate Medical Education Committee, with any information that it requests in connection with this application. I hereby voluntarily, specifically, and intentionally release any and all of these persons, institutions, entities, LLUH and the Graduate Medical Education Committee, from any and all liability for any damages whatsoever arising out of the investigation of this application.

SIGNATURE OF APPLICANT	DATE (Month/Day/Year)

SUBMIT COMPLETED APPLICATION AND ALL REQUIRED DOCUMENTATION (listed the last page) TO:

Program Director of Specialty to which the application is being made.
Loma Linda University Health
Loma Linda, CA 92354

Questions regarding the completion of this application may be emailed to the Graduate Medical Education Office, gmeo@llu.edu.

REQUIRED DOCUMENTATION

In addition to a completed original Graduate Medical Education Application, the following documentation is REQUIRED. Photocopies of documentation are acceptable during the application process, however, an applicant who is accepted for training must provide ORIGINAL or CERTIFIED COPY (certifying document is an exact copy of the original) of all documentation shown with * below. Original documentation may be presented to the LLUH Graduate Medical Education Office.

It is the responsibility of the applicant to request all required documentation. All documentation must be submitted to the Program Director of the training program to which applicant is applying.

ALL APPLICANTS:

a. Current curriculum vitae-listing dates and all time since graduating medical school
b. * Dean's Letter
c. * Two reference letters from physicians currently acquainted with applicant
d. * Official medical school transcript(s), and translation if not in English
e. Copy of scores for each examination taken
f. Medical School Diploma and translation if not in English (if graduation is pending, copy of Diploma must be submitted to Graduate Medical Education Office before beginning training)

INTERNATIONAL MEDICAL GRADUATES must provide the following additional documentation:

a. ECFMG Certificate with current validation date

[redacted]

APPLICANTS WITH PREVIOUS U.S. TRAINING, PRACTICE EXPERIENCE OR MEDICAL STAFF MEMBERSHIP / PRIVILEGES must provide the following additional documentation:

a. * Reference letter from Program Director for each prior training program
b. Copy of California Medical License, if licensed
c. * Letter of good standing from licensing board of any state where applicant has been licensed
d. * Letter from Medical Staff Office of any facility where staff privileges have been held

PLEASE NOTE THE FOLLOWING INFORMATION

1. Mandatory drug testing and background check of all new residents or fellows is required by LLUH policy.
2. Residents are required to obtain a valid California medical license in the timeframe mandated by the Medical Board of California
3. The primary professional and general liability coverage for Loma Linda University Health is provided under a self-insurance trust program sponsored by Adventist Health System / Loma Linda. If further information regarding processional liability is needed contact the Graduate Medical Education Office, gmeo@llu.edu.

FOR OFFICE USE ONLY:

Date Received _____

Comments: _____

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