UW Health
University of Wisconsin Hospital and Clinics
uwhealth.org

UWHC Graduate Medical Education Application

Please make sure you are using a PC with a current Adobe Reader installed for correct completion.

Program Applying To	Starting at PG Level?	Anticipated Training Dates From __/__ To __/__ (month/yr to month/yr)	

I. General Information

First Name:	
Middle Name:	
Last Name:	
Suffix:	
Previous Last Name:	
Degree:	
USMLE ID:	
AAMC ID:	
National Practitioner Identification (NPI):	
Match Participation	
Partner's Name: (if applicable)	
Specialty partner is applying to: (if applicable)	
Match participation other than NRMP?	

Current Mailing Address

Street Address:					
City:		**State/Province:**		**Postal Code:**	
Country:					
Home Phone:					
Cell Phone:					
Preferred Phone:					
Pager:					
Fax:					
Contact Email:					

Permanent Mailing Address

Street Address:					
City:		**State/Province:**		**Postal Code:**	
Country:					

Home Phone:	
Cell Phone:	
Preferred Phone:	
Pager:	
Fax:	
Contact Email:	

II. MILITARY

Are you committed to fulfill U.S. Military active duty service obligations/deferments?	Yes No If Yes, Years: Branch:
Do you have any other service obligations? (i.e., Military Reserves or Public Health/State programs)	Yes No Description:

III. MEDICAL LICENSURE

Has your medical license ever been suspended/ revoked/ voluntarily terminated? Provide attachment if further room necessary. (Reference as III-a)	No Yes Reason:
Have you ever been named in a malpractice case? Attach a Malpractice Claims History Provide attachment if further room necessary. (Reference as III-b)	No Yes Reason:
Is there anything in your past history that would limit your ability to be licensed or to receive hospital privileges? Provide attachment if further room necessary. (Reference as III-c)	No Yes Reason:
Have you ever been convicted of a felony? Provide attachment if further room necessary. (Reference as III-d)	No Yes Reason:

IV. STATE MEDICAL LICENSES

None

#1

License Type	License Number	State	Expiration Date (month/yr)
Full Temporary or Limited Inactive			__/__

#2

License Type	License Number	State	Expiration Date (month/yr)
Full Temporary or Limited Inactive			__/__

V. CARDIOPULMONARY RESUSCITATION & OTHER LIFE SAVING INTERVENTION CERTIFICATE

I am CPR/BLS (Cardiopulmonary Resuscitation) certified in the U.S.A	Expiration Date: __/__ (Month/Year)
I am ACLS (Advanced Cardiac Life Support) certified in the U.S.A	Expiration Date: __/__ (Month/Year)
I am PALS (Pediatric Advanced Life Support) certified in the U.S.A	Expiration Date: __/__ (Month/Year)
I am ATLS (Advanced Trauma Life Support) certified in the U.S.A	Expiration Date: __/__ (Month/Year)
I have a current DEA Registration Number (if applicable)	Number:
DEA Registration Expiration (Month/Yr)	Expiration Date: __/__ (Month/Year)

VI. EXAMINATIONS

___USMLE OR ___COMLEX

	Status (check appropriate button)	Attempt # (circle)	Results/ Score	Date Month/Yr Passed
Step I	**•Will take on __/__ •Awaiting results**	**1 2 3**	**Passed/___ Failed/___**	**__/__**
Step 2 – (CK, if USMLE)	**•Will take on __/__ •Awaiting results •Incomplete**	**1 2 3**	**Passed/___ Failed/___**	**__/__**
Step 2 (CS, if USMLE)	**•Will take on __/__ •Awaiting results •Incomplete**	**1 2 3**	**Passed/___ Failed/___**	**__/__**
Step 3 ___	**Will take on __/__ Awaiting results Incomplete**	**1 2 3**	**Passed/___ Failed/___**	**__/__**

VII. AMERICAN BOARD OF MEDICAL SPECIALTIES CERTIFICATION

_____(EXAMPLE: ABR, ABIM) OR ___N/A

Board Name/Specialty	Expiration Date (month/yr)
	__/__
	__/__

VIII. MEDICAL EDUCATION

Institution & Location Institution Name City, State	Dates Attended From _____ To _____ (Month/Year) (Month/Year)	Degree	Date of Degree

IX. EDUCATION

Education	Institution & Location	Dates Attended From _____ To _____ (Month/Year) (Month/Year)	Degree	Degree Date (Month/Yr)	Field of Study
Undergraduate Graduate Other					
Undergraduate Graduate Other					
Undergraduate Graduate Other					

X. CURRENT/PRIOR TRAINING None

Specialty	Type of Training	Dates of Residency/Fellowship From _____ To _____ (Month/Year) (Month/Year)	Institution/Program	City, State	Program Director	Program Supervisor
	Internship Residency Fellowship					
Reason for leaving: Provide attachment if further room necessary. (Reference as X-a)						
Specialty	**Type of Training**	**Dates of Residency/Fellowship** From _____ To _____ (Month/Year) (Month/Year)	**Institution/Program**	**City, State**	**Program Director**	**Program Supervisor**
	Internship Residency Fellowship					

Reason for leaving: Provide attachment if further room necessary. (Reference as X-b)						
Specialty	**Type of Training**	**Dates of Residency/Fellowship** From _____ To _____ (Month/Year) (Month/Year)	**Institution/Program**	**City, State**	**Program Director**	**Program Supervisor**
	Internship Residency Fellowship					
Reason for leaving: Provide attachment if further room necessary. (Reference as X-c)						

Was your medical education/training extended or interrupted? *Please explain any gaps of 3 or more months during your medical education and/or residency training.*	**___No** **___Yes** If so, reason:

Provide attachment if further room necessary. (Reference as X-d)

XI. EXPERIENCE

Experience Type	Organization & Location	Position	Dates	Supervisor	Avg. Hrs/Wk
Work Research Volunteer					
Reason for Leaving: Provide attachment if further room necessary. (Reference as XI-a)					
Experience Type	**Organization & Location**	**Position**	**Dates**	**Supervisor**	**Avg. Hrs/Wk**
Work Research Volunteer					
Reason for Leaving: Provide attachment if further room necessary. (Reference as XI-b)					
Experience Type	**Organization & Location**	**Position**	**Dates**	**Supervisor**	**Avg. Hrs/Wk**
Work Research Volunteer					
Reason for Leaving: Provide attachment if further room necessary. (Reference as XI-c)					

Are you able to carry out the responsibilities of a resident in the specialties and at the specific training program to which you are applying including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements with or without reasonable accommodations? Please check below		
Yes	**No Response**	**No - Please describe limiting aspects on Appendix A.**