

The Johns Hopkins Hospital  
600 North Wolfe Street  
Baltimore MD 21287

Johns Hopkins Bayview Medical Center  
4940 Eastern Avenue  
Baltimore MD 21224

The Johns Hopkins University  
School of Medicine  
720 Rutland Avenue  
Baltimore MD 21205

**APPLICATION FOR APPOINTMENT TO:**

**Residency Training Program**

**OR**

**Fellowship:**

*For The Johns Hopkins Hospital only:*

- Categorical beginning PGY-1 (Intern)  
 Advanced beginning PGY-2 or above (Resident)

- Clinical  
 Research  
 Clinical and Research

*For Johns Hopkins Bayview Medical Center only:*

**OR**

- Straight Medicine Track  
 General Internal Medicine Track  
 Both

Rotator  
Parent Institution \_\_\_\_\_

Location:  The Johns Hopkins Hospital

Johns Hopkins Bayview Medical Center

**Department / Division:**

Service: \_\_\_\_\_ To Begin \_\_\_\_\_  
(Date)

**Instructions:** Complete all sections (please print or type all responses). If a section does not pertain to you, mark as N/A (not applicable). Do not leave any section blank nor make reference to an attached CV.

1. Name:	Last	First	Middle
2. Other Name Used:	Last	First	Middle
3. Current / Local Address (include street, city, state, and zip):			
4. Current / Local Telephone Number:			
5. Permanent Address (include street, city, state, and zip):			
6. Emergency Contact: Name	Relationship	Mailing Address	Telephone Number
7. E-mail Address:			

Applicant's Name [printed] \_\_\_\_\_

8. Citizenship: Are you a citizen of the United States:  Yes  No If no, complete the following:  
Citizenship \_\_\_\_\_ Visa Type \_\_\_\_\_  
Entrance Date into U.S. \_\_\_\_\_ Length of Stay Valid to \_\_\_\_\_  
Do you have INS permission to work?  Yes  No  
Do you have INS permission to be involved in direct patient care?  Yes  No  
Is your degree of patient care involvement limited by your visa?  Yes  No

9. Current Position or Scientific Activities:

10. College(s) Attended (undergraduate education):

Name(s) of School : \_\_\_\_\_  
Mailing Address : \_\_\_\_\_  
Month/Years Attended : \_\_\_\_\_ Degree(s) Conferred: \_\_\_\_\_

(Use continuation sheet, if necessary)

11. Professional Education (medical school) or other doctoral program:

Name(s) of School : \_\_\_\_\_  
Mailing Address : \_\_\_\_\_  
Month/Years Attended : \_\_\_\_\_ Degree(s) Conferred: \_\_\_\_\_

(Use continuation sheet, if necessary)

12. For International Medical School Graduates: ECFMG No. \_\_\_\_\_ Valid to \_\_\_\_\_  
(Provide a copy of your certificate)

13. Internship, Residencies, Other Postdoctoral Training & Fellowship Programs:

\* Name(s) of School : \_\_\_\_\_  
Mailing Address : \_\_\_\_\_  
Dates Attended (Month/Years): \_\_\_\_\_ Service or Subject: \_\_\_\_\_

\* Name(s) of School : \_\_\_\_\_  
Mailing Address : \_\_\_\_\_  
Dates Attended (Month/Years): \_\_\_\_\_ Service or Subject: \_\_\_\_\_

\* Name(s) of School : \_\_\_\_\_  
Mailing Address : \_\_\_\_\_  
Dates Attended (Month/Years): \_\_\_\_\_ Service or Subject: \_\_\_\_\_

(Use continuation sheet, if necessary)

Applicant's Name [printed] \_\_\_\_\_

14. National Board of Medical Examiners:

Diploma:  Yes (attach copy) Date: \_\_\_\_\_  No  
Board Scores for NBME: Part I \_\_\_\_\_ Part II \_\_\_\_\_  
USMLE Scores: Step I \_\_\_\_\_ Step II \_\_\_\_\_ Step III \_\_\_\_\_  
Clinical Skills Assessment Test Score: \_\_\_\_\_

15. Hospital Appointments (other than what is included in your training program): List chronologically, appointments to other hospital staffs showing name of hospital, mailing address of hospital, type of appointment (e.g., Active, Moonlighter, OPD, etc.)

\* Name of Hospital: \_\_\_\_\_  
Current Mailing Address: \_\_\_\_\_  
Dates of Appointment : \_\_\_\_\_ Type of Appointment: \_\_\_\_\_

\* Name of Hospital: \_\_\_\_\_  
Current Mailing Address: \_\_\_\_\_  
Dates of Appointment : \_\_\_\_\_ Type of Appointment: \_\_\_\_\_

(Use continuation sheet, if necessary)

16. Teaching Appointments (other than what is included in your training program): List chronologically, any teaching appointments showing name of institution and mailing address of institution.

\* Name of Institution: \_\_\_\_\_  
Current Mailing Address: \_\_\_\_\_  
Dates of Appointment : \_\_\_\_\_ Type of Appointment: \_\_\_\_\_

\* Name of Institution: \_\_\_\_\_  
Current Mailing Address: \_\_\_\_\_  
Dates of Appointment : \_\_\_\_\_ Type of Appointment: \_\_\_\_\_

(Use continuation sheet, if necessary)

17. Please explain any gaps in time / interruptions in clinical training and/or appointments since receipt of medical or professional degree. **Any gap of one month or more must be explained.**

(Use continuation sheet, if necessary)

18. Licensure: List any health occupation license or registration ever held, showing state(s), country(ies), number(s), date(s), and status.

19. Member or Fellow of (e.g., AMA, ACS, etc.): List all past or present memberships

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20. Awards and Honors Received:

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21. Scientific or Clinical Interest:

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22. Publications (attach list in lieu of listing here):

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23. Languages Spoken:

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24. Medical References (for clinical applicants): Names and addresses of four (4) physicians who have worked extensively with you or have been responsible for professional observation of you. Do not list: relatives by blood or marriage; the Chief of Service to which you are applying; persons in current training program with you; nor persons who cannot attest to your current level of clinical competency, technical skill, and medical knowledge.

Name	Mailing Address	Day-time Telephone
€ _____	_____	_____
	_____	Fax # _____
	_____	
	_____	
€ _____	_____	_____
	_____	Fax # _____
	_____	
	_____	
∠ _____	_____	_____
	_____	Fax # _____
	_____	
	_____	
∇ _____	_____	_____
	_____	Fax # _____
	_____	
	_____	

Applicant's Name [printed] \_\_\_\_\_

**Continuation Page:** Use this page to document additional information. Copy as necessary.

**Statement of Applicant:**

-- I fully understand that any significant misstatements in, or omissions from, this application may constitute cause for denial of appointment to or summary dismissal from, the Hospital Medical Staff and/or The Johns Hopkins University.

-- All information submitted by me in this application is true to the best of my knowledge and belief.

-- I authorize the Hospital and/or the University and their representatives to consult with other hospitals and institutions and their representatives and others, in regard to this application.

-- I release from liability the Hospital and/or University, their representatives and agents for their actions or omissions performed in good faith and without malice in evaluating the application as well as those who provide information to the Hospital and/or University in good faith and without malice, and I consent to the release of such information, including otherwise privileged or confidential information.

-- I consent to the release of information to other hospitals and institutions and persons with a legitimate interest and agree to hold the Hospital and/or the University, their representatives and agents free of liability for their actions performed in good faith as a part of the quality assurance program, the credentialing process, peer review and medical evaluation activities.

-- I understand that the information required herein is continuing in nature and I agree to provide any changes in the information provided; i.e., address, name, certification and dates, licensure, etc. I agree to furnish, upon request, an update on any information provided in this application.

*A copy of the Statement of Applicant may be used as original.*

Date \_\_\_\_\_

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

The Johns Hopkins Institutions do not discriminate on the basis of race, color, sex, religion, age, national or ethnic origin, sexual orientation, handicap, veteran status, or any other occupationally irrelevant criteria.

Name \_\_\_\_\_  
please print

Department to which Applying \_\_\_\_\_

Date Completed \_\_\_\_\_

## Supplemental Biographical Information

The information requested is for statistical purposes only and will not be used during consideration of the application.

1. Date of Birth

2. Place of Birth

3. Gender

Male

Female

4. Ethnicity/Race:

(Self-Identification)

A. Ethnicity:

Of Hispanic or Latino Origin (a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race).

Not of Hispanic or Latino origin

B. Race:

Black or African American: A person having origins in any of the original groups of Africa.

Asian: Includes persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian sub-continent (e.g., Cambodia, China, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam).

American Indian or Alaskan native: Includes persons having origins in any of the original peoples of North America and South America (including Central America), and who maintains tribal affiliation or community attachment.

Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

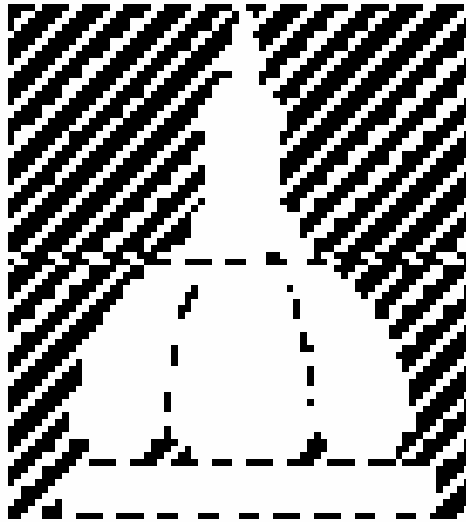
White: Includes persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

5. Marital Status:

6. Name of Spouse:

7. Name(s) of Children and Year(s) of Birth:

# Johns Hopkins Medicine



Application for  
Residency / Fellowship Training Program



## **General Instructions for Completion of this Application**

\* Each section must be **complete** and **legible** or your application will be deemed incomplete and returned to you. This pertains to any attachment you include with the application; e.g., CV, copies of licenses, certifications, etc.

- < The verification process on your education, training, and experience will not begin until a completed application has been received.
  
- < Do not refer to an enclosed curriculum vitae in lieu of completing a section. A CV does not usually contain all the information needed (e.g., complete dates, addresses, names, etc.).
  
- < If a section does not apply to you, write in N/A. Do not leave any block blank.

\* **All chronology must be accounted for from the completion of your medical/professional degree, to the present.** Gaps of one month or more will cause the verification process to be delayed until you provide an explanation. Delays can also be caused by incomplete names and addresses -- please provide complete information in all sections.

\* If additional space is needed, attach additional pages (make reference to the question being answered) or, copy the blank application page as often as necessary to provide complete information. Keep these additional pages in sequence with corresponding application pages.