TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER™ *at the* Permian Basin

APPLICATION FOR RESIDENCY/FELLOWSHIP TRAINING

PHOTO Please attach photograph with your signature on the front surface 2" x 2" (Optional)

*Please indicate the program for which you are applying: Specialty:*_____

*Subspecialty (if any):*_____

From: _____ *to:*_____
Date Date

Post-Graduate Year: 4

PLEASE TYPE FULL INFORMATION AS APPLICABLE (Use additional sheets when necessary)

PERSONAL

NAME (LAST)	(FIRST)	(MIDDLE)	PHONES: DAY	Evening
PRESENT ADDRESS (STREET)	(CITY)	(STATE)	(Zip)	
PERMANENT ADDRESS: C/O (NAME OF PERSON THROUGH WHOM I CAN ALWAYS BE CONTACTED)		(STREET)		
(CITY)	(STATE)	(ZIP)	(PERMANENT PHONE NUMBER)	
SOCIAL SECURITY NUMBER (OPTIONAL)	DATE OF BIRTH (OPTIONAL)	PLACE OF BIRTH (OPTIONAL)		
DO YOU HAVE A MILITARY OBLIGATION? IF YES, PLEASE EXPLAIN-IF DISCHARGED FROM MILITARY, TYPE OF DISCHARGE			VISA Status (if applicable) ☐ PERMANENT ☐ J-1 ☐ Temporary –Specify _____ ☐ Other—Specify _____	
SHALL PARTICIPATE IN NRMP MATCH ☐ YES ☐ NO	NMRP CODE (enter "pending" if unknown)	ECFMG CERTIFICATION (if applicable)		

TRAINING

PREMEDICAL TRAINING:		DEGREE:	DATE:
		DEGREE:	DATE:
MEDICAL SCHOOL:		CITY:	
EXACT GRADUATION DATE:		DEGREE:	STATE OR COUNTRY:

RESIDENCIES OR FELLOWSHIPS:	(TYPE)	(HOSPITAL)	(ADDRESS)	(DATE)
	(TYPE)	(HOSPITAL)	(ADDRESS)	(DATE)
	(TYPE)	(HOSPITAL)	(ADDRESS)	(DATE)

**LETTER(S) FROM PROGRAM DIRECTOR(S) WITH DATES IN PROGRAM(S) AND MONTHS SATISFACTORILY COMPLETED IS REQUIRED

LICENSURE STATUS

ARE YOU PRESENTLY LICENSED TO PRACTICE MEDICINE IN THE STATE OF TEXAS? ☐ YES ☐ NO LICENSE NUMBER: _____

ARE YOU CURRENTLY, OR HAVE YOU BEEN, LICENSED TO PRACTICE IN ANY OTHER STATE? ☐ YES ☐ NO LICENSE NUMBER: _____

STATE: _____

IF YES, DO YOU PLAN TO FILE FOR LICENSE IN TEXAS BY ENDORSEMENT? ☐ YES ☐ NO IF SO, WHEN? _____

PROFESSIONAL LIABILITY

HAVE THERE BEEN OR ARE THERE CURRENTLY PENDING ANY MALPRACTICE CLAIMS, SUITS, SETTLEMENTS OR ARBITRATION PROCEEDINGS INVOLVING YOUR PROFESSIONAL MEDICAL PRACTICE? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE LIST AND STATUS ON SPATE SHEET.

DISCIPLINARY ACTIONS

Have any of the following ever been, or are any currently in the process of being investigated, denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? If yes, please provide a full explanation on a separate sheet.

Medical license in any state	☐ YES ☐ NO
Other professional registration/license	☐ YES ☐ NO
DEA/controlled substance registration	☐ YES ☐ NO
Membership on any hospital medical staff	☐ YES ☐ NO
Clinical privileges or prerogatives/rights on any medical staff	☐ YES ☐ NO
Other institution affiliation (e.g. medical school, HMO, etc.)	☐ YES ☐ NO
Professional society membership or fellowship/Board certification	☐ YES ☐ NO
Any other type of professional sanction	☐ YES ☐ NO
Have there been any felony criminal charges or charges of crimes involving moral turpitude brought against you in the last five years?	☐ YES ☐ NO

If yes, please provide full explanation on separate sheet, including the resolution of charges

HEALTH STATUS

Do you have any physical or mental condition, including alcohol or drug dependency, which results in your inability to perform the essential functions of the position and to exercise the clinical privileges requested, with or without reasonable accommodation?	☐ YES ☐ NO
Are you currently in a monitoring or assistance program for alcohol or drug dependency?	☐ YES ☐ NO
Do you currently engage in illegal drug use or illegal use of controlled dangerous substances	☐ YES ☐ NO

(If yes, please provide full explanation on separate sheet)

REFERENCES

LETTERS OF REFERENCE, IN ADDITION TO THE DEAN'S LETTER, HAVE BEEN REQUESTED FROM THE FOLLOWING INDIVIDUALS:

Name and Title	Institution	Address
1.		
2.		
3.		

NOTARIZED COPY OF ORIGINAL MEDICAL SCHOOL DIPLOMA AND/OR OFFICAL TRANSCRIPT IS TO BE RETURNED WITH THIS APPLICATION.

BOTH DOCUMENTS ARE REQUIRED FOR RESIDENCY

PLEASE ATTACH PERSONAL STATEMENT AND CURRICULUM VITAE
AND RETURN COMPLETED APPLICATION TO:

Texas Tech University Health Sciences Center
Director of Fellowship Training
Department of Family Medicine
701 W. 5th Street
Odessa, TX 79763

I FULLY UNDERSTAND THAT ANY MISSTATEMENTS IN OR OMISSIONS FROM THIS APPLICATION CONSTITUTE CAUSE FOR DENIAL OF ACCEPTANCE IN OR CAUSE FOR SUMMARY DISMISSAL FROM THE RESIDENCY/FELLOWSHIP TRAINING PROGRAM. ALL INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE TO MY BEST KNOWLEDGE AND BELIEF. I ACKNOWLEDGE THAT TTUHSC HAS THE RIGHT TO REQUEST ADDITIONAL INFORMATION NOT PROVIDED ON THIS APPLICATION, AND I AGREE TO CONFORM TO ALL RULES AND REGULATIONS OF TTUHSC.

Date _____ Signature of Applicant _____

_____

Applicants Name (print in black ink or type)

REQUIREMENTS FOR RESIDENCY

Passage of USMLE 1, passed within the number of attempts required for Texas licensure.

Any other licensing exams taken prior to residency must be passed within the number of attempts required for Texas licensure.

EXAMINATION HISTORY

EXAMINATION	# OF ATTEMPTS	MOST RECENT DATE TAKEN (MO/YR)		DATE PASSED (MO/YR)	
ECFMG (Basic)	_____	_____	_____	_____	_____
ECFMG (Clinical)	_____	_____	_____	_____	_____
ECFMG (English)	_____	_____	_____	_____	_____
FLEX Component 1	_____	_____	_____	_____	_____
Flex Component 2	_____	_____	_____	_____	_____
Pre-1985 Flex	_____	_____	_____	_____	_____
USMLE Step 1	_____	_____	_____	_____	_____
USMLE Step 2	_____	_____	_____	_____	_____
USMLE Step 3	_____	_____	_____	_____	_____
NBME Part 1	_____	_____	_____	_____	_____
NBME Part 2	_____	_____	_____	_____	_____
NBME Part 3	_____	_____	_____	_____	_____
NBOME Part 1	_____	_____	_____	_____	_____
NBOME Part 2	_____	_____	_____	_____	_____
NBOME Part 3	_____	_____	_____	_____	_____
SPEX	_____	_____	_____	_____	_____
LMCC	_____	_____	_____	_____	_____
State Board Exam					
_____					
(Name of state)					

1. Have you ever been denied the privilege of taking an examination administered by a U.S. state and/or Canadian provincial licensing agency?
☐ Yes ☐ No If yes, give full details: _____

2. Have you ever failed any examination or part thereof, including FLEX, SPEX, LMCC, NBOME, USMLE, ECFMG, state licensing agency examination, as required by this state or any other U.S. state and/or Canadian provincial licensing agency? ☐ Yes ☐ No
If yes, give full details: _____

I,_____ hereby certify under oath that the information is true and correct.

_____
Signature of Applicant

Subscribed and sworn to before me this_____day of_____, 20_____.

(Notary seal)

_____
(Notary Public)