Instruction for Completion of Application for Appointment to Graduate Medical Education at University of North Carolina Hospitals

Chapel Hill, North Carolina 27514

*Please **electronically** complete all required information on the application form.*

Applicants applying for 1st Year Post Graduate Positions must mail directly to the Training Program to which you are applying the following documents:

1. Application for Graduate Medical Education at the University of North Carolina Hospitals; and
2. Three letters of reference.
   a. One (1) Medical Student Performance Evaluation (MSPE) from the medical school where the Resident graduated, or if an MSPE is not available, a Dean's (or Dean's designee) letter of reference from the medical or dental school from which the Resident graduated, and;
   b. Two (2) letters of reference from members of the medical or dental staff of the hospital affiliated with the medical or dental school from which the Resident graduated, or from physicians (for medical residents) or dentists (for dental residents) with current knowledge of the Resident's experience, ability, educational accomplishments and character (which may include, but is not required to include, the Chairman of the chosen specialty or his/her designee).
3. An official, final Medical/Dental School transcript from the Registrar of the school of Medicine or Dentistry. A photocopy is not acceptable. The transcript must be mailed directly to the program.
4. Read carefully and hand-sign the Acknowledgement & Waiver and the separate Authorization to Obtain Consumer Report.

Applicants applying for above 1st-Year Post Graduate Positions, including applicants who are changing specialties, must mail directly to the Training Program to which you are applying the following documents:

1. Application for Graduate Medical Education at the University of North Carolina Hospitals; and
2. Three letters of reference.
   a. One (1) letter of reference from the Program Director of the residency program in which the Resident has most recently served; and
   b. Two (2) letters of reference from members of the medical or dental staff of the hospital affiliated with the residency program from which the Resident has most recently served, or from physicians (for medical residents) or dentists (for dental residents) with current knowledge of the Resident's experience, ability, educational accomplishments and character (which may include, but is not required to include, the Chairman of the chosen specialty or his/her designee).
3. An official, final Medical/Dental School transcript from the Registrar of the School of Medicine or Dentistry. A photocopy is not acceptable. The transcript must be mailed directly to the program.
4. Read carefully and hand-sign the Acknowledgement & Waiver, and the separate Authorization to Obtain Consumer Report.

The responsibility for securing letters of reference rests with the applicant. *This application, all letters of reference, transcripts and supporting documents should be addressed directly to the Chief of Service or Director of the Training Program in which the applicant is interested.* DO NOT have recommendation letters sent directly to the Director of Graduate Medical Education or just to UNC Hospitals.

University of North Carolina Hospitals: Application for Graduate Medical Education

Answer each question completely and electronically; answers must be typed, not handwritten. Do not leave anything blank and do not reference other materials (e.g., ERAS application or CV). Select N/A for all questions not applicable.

Name _____
Last First Middle

Training Program: Select to Choose

Anticipated Starting Date: Select GME Agreement Start Date

Position Applying for: Select PGY level you are entering

Stipend levels for trainees entering programs beyond their first core residency training program will be determined on the basis of the number of accredited years required by the ACGME for eligibility in that program regardless of any other advanced or GME training the trainee may have completed.

Applicant Contact Information:

_____
Present Home Address (mailing)

_____
City, County, State, ZIP code

_____
Personal Home Telephone #

_____
Personal Email Address

Medical School/Residency Contact Information

_____
School or Hospital Address

_____
City, State, ZIP Code

_____
School/Dean's Office/Residency Office Telephone #

Are you legally authorized to work in the U.S.? Yes ☐ No ☐

Do you require a work visa to be legally authorized to work in the U.S.: Yes ☐ No ☐

If Yes, please list the type of visa: _____

*Note: The H-1B visa is not accepted for graduate medical education programs at UNC Hospitals.

Are you registered with any Matching Program?

Yes ☐ No ☐ If yes, which one:
NRMP ☐ Other ☐ _____ (list)
NRMP # _____

If you want your application considered in conjunction with that of another person, please provide the following information about that person. **Not applicable** ☐

Name _____

Program _____

College Education

School _____

Major _____

Degree _____

Inclusive Dates _____
(Month/Year) to (Month/Year)

Medical and Dental Education

School _____

Degree _____

Inclusive Dates _____
Dates Attended: From (MM/DD/YYYY) to (MM/DD/YYYY)

Please list all residency programs, graduate programs, or any other postgraduate training experiences.

(All ACGME experience must be indicated on the application itself. Please use additional sheets as necessary; if not applicable, please indicate so.)

1. Program _____
Not applicable ☐

Institution/School _____

Inclusive Dates (MM/DD/YYYY) _____ to _____

Satisfactorily Completed _____

2. Program _____
Not applicable ☐

Institution/School _____

Inclusive Dates (MM/DD/YYYY) _____ to _____

Satisfactorily Completed _____

3. Program _____
Not applicable ☐

Institution/School _____

Inclusive Dates (MM/DD/YYYY) _____ to _____

Satisfactorily Completed _____

Professional Experience – Teaching Appointments & Practice

(Other than Medical/Dental Trainee Status. Please use additional sheets as necessary. If not applicable, please indicate so.)

1. Employer _____
Not applicable ☐

_____
Address (City, State and ZIP Code)

Phone _____

Position _____

Full or Part Time _____

_____
Dates Employed: From (MM/DD/YYYY) to (MM/DD/YYYY)

Reason for Leaving _____

2. Employer _____
Not applicable ☐

_____
Address (City, State and ZIP Code)

Phone _____

Position _____

Full or Part Time _____

_____
Dates Employed: From (MM/DD/YYYY) to (MM/DD/YYYY)

Reason for Leaving _____

Names of references from whom we may expect letters:

See requirements on page 1

_____
1. Name

_____
Title

_____
2. Name

_____
Title

_____
3. Name

_____
Title

Have you obtained ECFMG certification?
Yes ☐ (fill info below) No ☐ (explain) Not Applicable ☐
ECFMG Certificate #_____
Date _____

Medical/Dental Licensure

List all medical/dental licenses you currently hold or have ever held (including resident training licenses) in any state; please provide the state(s), type of license(s), and license number(s).

Not applicable (currently in medical school) ☐
Not applicable (state does not require residents to have a license) ☐

Type of License/State/Number _____

Have you ever had any license revoked, suspended, denied, restricted, limited or issued/placed in a probationary status or voluntarily relinquished?

Yes ☐ No ☐ N/A ☐

If yes, attach a full explanation to this application.

NPI Number
Have you been issued an NPI number?
Yes ☐ No ☐

If yes, provide number _____

Are you able, physically and mentally, to practice medicine safely and competently with or without reasonable accommodation?

Yes ☐ No ☐ (explain) Uncertain ☐ (explain)

Military Experience or National Health Programs (NIH, PHS, IHS, etc.) Not applicable ☐

Type of Discharge _____

Subject to active duty? Yes ☐ No ☐

Do you intend to request VA benefits? Yes ☐ No ☐

Have you ever pled guilty, been found guilty by judge or jury, or pled no contest to a violation of federal, state, or local law, other than a minor traffic violation? (Do not disclose information that has been expunged from your record.)
Yes ☐ (explain) No ☐

Have you ever been CHARGED with driving under the influence or while impaired?
Yes ☐ (explain) No ☐

Have you ever been voluntarily or involuntarily placed on probation, suspended or terminated from a Medical/Dental School Residency Program or Medical or Dental Staff?
Yes ☐ (explain) No ☐

Was your Medical or Dental School training interrupted for any reason?
Yes ☐ (explain) No ☐

Professional Sanctions/Charges/Violations

Are you now, or have you ever been, involved in any litigation, lawsuits, claims or arbitration related to your professional activities?
Yes ☐ (explain) No ☐

Have judgments or settlements been made against you in professional liability cases or are you involved in any pending litigation involving professional liability?
Yes ☐ (explain) No ☐

Have you ever been denied liability insurance?
Yes ☐ (explain) No ☐

Has your membership or renewal thereof in any medical organization ever been revoked, suspended, diminished or denied?
Yes ☐ (explain) No ☐

Have your privileges in any hospital ever been suspended, diminished, revoked or not renewed?
Yes ☐ (explain) No ☐

Please notify the training program immediately if any of your responses on this application change.

Acknowledgment and Waiver

By applying to a residency/fellowship program at the University of North Carolina Hospitals, I hereby confirm that I am willing to appear in person for interviews in connection with my application.

I understand that in connection with my application, I am required to review and sign a separate Authorization to Obtain Consumer Report, which allows UNC Hospitals' Office of Graduate Medical Education to utilize a Consumer Reporting Agency (CRA) to prepare a consumer report or investigative consumer report about me.

I authorize my current and former employers, any law enforcement agency, administrator, local, state or federal agency, institution, school or university, information service bureau, insurance company, or other persons or agencies having knowledge about me to provide any and all requested information to the University of North Carolina Hospitals Office of Graduate Medical Education. I understand that this authorization shall remain in effect for the duration of my employment with UNC Hospitals.

I hereby release from liability all representatives of UNC Hospital and the Schools of Medicine/Dentistry for their acts performed in good faith in evaluating my application, my credentials, my consumer report, and my qualifications. I also hereby release from liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to UNC Hospital and the Schools of Medicine/Dentistry in good faith and without malice concerning my professional status or other qualifications.

I certify that all statements on this application are true and complete to the best of my knowledge. I understand that any misstatements, omissions, or falsification in any document related to this application may result in rejection of my application or my dismissal if I am employed. I understand that if I become employed by the University of North Carolina Hospitals or the University of North Carolina Schools of Medicine/Dentistry, I will be required to produce original documents verifying (1) my identity, and (2) my authorization to work in the United States, in compliance with the Federal Immigration Reform and Control Act of 1986.

I understand that if I am accepted into the Graduate Medical Education program at UNC Hospitals, it is mandatory that I immediately provide my Social Security Number to the Office of Graduate Medical Education because UNC Hospitals must disclose my Social Security Number pursuant to various federal and state laws involving taxes, income, and debt owed to the state. Accordingly, upon my admission to UNC Hospitals' Graduate Medical Education program, I will immediately provide my Social Security Number to the Office of Graduate Medical Education.

I understand that any offer of employment as a resident or fellow at UNC Hospitals is contingent upon my passing a pre-employment substance abuse screening and background check, including verification of prior education, employment, and criminal background.

Signature _____
(*This document must be hand-signed)

Please Type Name _____

Date _____

AUTHORIZATION TO OBTAIN CONSUMER REPORT

DISCLOSURE STATEMENT

In connection with your application for employment in the UNC Residency Program, UNC Hospitals' Office of Graduate Medical Education may utilize a Consumer Reporting Agency (CRA) to prepare a consumer report or investigative consumer report, which may include information concerning your character, employment history, general reputation, personal characteristics, police record, criminal records, education, qualifications, motor vehicle record, professional credentials, mode of living and/or credit and indebtedness.

AUTHORIZATION

I have read and understand the foregoing Disclosure Statement, and authorize UNC Hospitals' Office of Graduate Medical Education to obtain and rely upon consumer reports or investigative consumer reports from a CRA for purposes of making decisions regarding my employment. I authorize my current and former employers, any law enforcement agency, administrator, local, state or federal agency, institution, school or university, information service bureau, insurance company, or other persons or agencies having knowledge about me to provide any and all background information requested by a CRA on behalf of UNC Health Care for purposes of preparing a consumer report or investigative consumer report. I understand that this authorization shall remain in effect for the duration of my employment with UNC Hospitals.

By my signature below, I authorize UNC Hospitals' Office of Graduate Medical Education to obtain consumer reports or investigative consumer reports from a CRA and to share the information received with any person involved in making decisions about my employment.

Signature
(*This document must be hand-signed)

Date

Please Type Name