

APPLICATION FOR RESIDENCY/FELLOWSHIP PROGRAM (PAGE 1 OF 2)

Start Date: \_\_\_\_\_ Mark appropriate level:  PGY I  PGY II  PGY III  PGY IV  PGY V  PGY VI

Training Program:  Anesthesiology  Emergency Medicine  Family Practice – Alexandria  
 Family Practice – S'port  Internal Medicine – Cat.  Internal Medicine – Prelim.  
 Medicine/Pediatrics  Neurosurgery  Obstetrics & Gynecology  
 Ophthalmology  Oral Surgery  Orthopaedics  
 Otolaryngology  Pathology  Pediatrics  
 Psychiatry  Radiology  Surgery  
 Urology  Fellowship (Specify Program): \_\_\_\_\_

Personal Information: Please Type or Print Legibly

Name in Full \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Last First MI

Any other name(s) you have ever been known by: \_\_\_\_\_

Present Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City State

Permanent Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City State

Emergency Contact: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City State

Citizenship: \_\_\_\_\_ If not a U.S. Citizen – VISA status (provide copy) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth \_\_\_\_\_ Martial Status \_\_\_ Spouse's Name \_\_\_\_\_

This information is collected to complete equal opportunity reports required by law. You are not legally required to provide this information.  
Racial/Ethnic Group \_\_\_\_\_ Sex (Circle One): M F

Education:

Premedical: School: \_\_\_\_\_ Major: \_\_\_\_\_ Degree: \_\_\_\_\_  
Address \_\_\_\_\_ Zip Code: \_\_\_\_\_ Graduation Date: \_\_\_\_\_  
Street City State (M/D/Y)

Medical: School: \_\_\_\_\_  
Street City State Zip Code Country  
Degree: \_\_\_\_\_ Graduation Date (M/D/Y): \_\_\_\_\_ IMG (Circle One): Yes or No

IMG: ECFMG No. \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

Examination Results: USMLE I \_\_\_\_\_ USMLE II \_\_\_\_\_ USMLE III \_\_\_\_\_  
Date taken/Score Date taken/Score Date taken/Score

Other Examination Results (i.e. COMLEX): \_\_\_\_\_  
Type of Exam Date taken/Score

Licensed to practice medicine in state(s) of \_\_\_\_\_ License #(s) \_\_\_\_\_

ALL APPLICANTS MUST MEET THE LICENSING REQUIREMENTS OF THE  
LOUISIANA STATE BOARD OF MEDICAL EXAMINERS (LSBME).

Previous Training: (If there is a break in training, a detailed explanation must be provided on a separate sheet)

Internship (Specialty) \_\_\_\_\_ Dates \_\_\_\_\_ Name of Hospital \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code

Residency (Specialty) \_\_\_\_\_ Dates \_\_\_\_\_ Name of Hospital \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code

Physician References (Training Program Director, Supervisor, Preceptor, etc.)

1. Name \_\_\_\_\_ Address: \_\_\_\_\_  
2. Name \_\_\_\_\_ Address: \_\_\_\_\_  
3. Name \_\_\_\_\_ Address: \_\_\_\_\_

ALL APPLICANTS – Medical school transcript, Dean's letter, three (3) reference letters, and a personal statement/CV need to be sent to the Program Director of the program to which you are applying.

**LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER-  
SHREVEPORT & AFFILIATED HOSPITALS**

1501 KINGS HWY, P.O. BOX 33932  
SHREVEPORT, LA 71130-3932

**APPLICATION FOR RESIDENCY/FELLOWSHIP PROGRAM (PAGE 1 OF 2)**

	<b>Yes</b>	<b>No</b>
1. Have you had any physical injury or disease or mental illness or impairment which could reasonably be expected to affect your ability to practice medicine or other health profession?	_____	_____
2. Have you ever been addicted to or used in excess any drug or chemical substance including alcohol or have you ever been treated through a drug or alcohol rehabilitation program?	_____	_____
3. Are you now or have you ever been a patient in the psychiatric unit of a hospital/clinic?	_____	_____
4. Have you ever been charged with, and/or convicted of, pled guilty or nolo contendere to, violation of any municipal, county/parish, state or federal statute? <b>(Should not include minor traffic citations).</b>	_____	_____
5. Has your application for examination or license ever been rejected or denied?	_____	_____
6. Have you ever failed a licensure/certification examination? If yes, how many times? _____	_____	_____
7. Have you ever been denied membership in a state, county, or local professional society?	_____	_____
8. Has your membership in a state, county, or local professional society ever been revoked, suspended, placed on probation, or restricted in any manner?	_____	_____
9. Have you ever been denied, had suspended, revoked, or restricted, or voluntarily relinquished staff or clinical privileges in any hospital or health care institution or organization?	_____	_____
10. Have you had any malpractice claims filed against you within the last five (5) years?	_____	_____
11. Do you have a Federal DEA or Louisiana controlled substance permit? If yes, provide copies.	_____	_____
12. Have you ever voluntarily surrendered, or did you have suspended, revoked or restricted, your narcotics controlled substance license(s) or registration (state or federal)?	_____	_____
13. Have you ever voluntarily surrendered, or did you have suspended, revoked, placed on probation, or restricted in any manner, any professional license issued by any licensing authority?	_____	_____
14. Have you ever been the subject of any type of disciplinary action or inquiry by any licensing agency, hospital, institution, society, etc.?	_____	_____
15. Have you ever agreed to not seek re-licensure in any licensing jurisdiction?	_____	_____
16. Have you ever initiated a proceeding, suit, or action against another provider or institution?	_____	_____

**Any 'yes' response will require a detailed explanation on a separate sheet. Failure to provide an explanation will result in an incomplete application.**

**NOTE:** You are required to answer every question. Failure to do so will result in a delay and may cause your appointment to become null and void. *You may be required to provide additional information to complete your application.*

In making this application, I fully understand that it is my duty to promptly report any changes in the response(s) to the questions resulting during my practice in this institution, or any other setting or institution, and that failure to do so shall constitute cause for summary suspension and dismissal from the training program. I do hereby also specifically authorize the hospital and release it, its representatives, and all organizations and individuals who provide information to the hospital from liability in their obtaining information regarding any changes or potential changes in my response to these questions. I hereby waive all rights I may have against any person, or organization conveying such information or releasing such information to LSU Health Sciences Center-Shreveport.

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Applicant Printed Name: \_\_\_\_\_