

12 E.C.F.M.G. Certification of Status (for graduates of other than U.S. or Canadian medical schools only):

EDUCATION

13 High School & Address:		14 Date of Graduation:	
15 College & Address:		16 Dates of Attendance, Degree Obtained, Date of Graduation:	
17 College & Address:		18 Dates of Attendance, Degree Obtained, Date of Graduation:	
19 College & Address:		20 Dates of Attendance, Degree Obtained, Date of Graduation:	
21 Medical School & Address:		22 Dates of Attendance, Degree Obtained, Date of Graduation:	
23 Internship (Institution & Address:		24 From _____ To _____ 25 Type: () Rotating () Straight in _____	
26 Post-Internship Training: Yes () No ()			
27 Institution & Address:	28 Service or Subject:	29 No. of Mos.:	30 Date Completed;
31 Amount of Approved Specialty Training or Other Experience in Post-Internship Training Acceptable for Credit with Specialty Boards:			

32 Private Practice of Medicine (Location & Dates), if applicable:

33 Honors Received (give details):

34 Special Work or Medically-related interests, Including Publications:

35 Membership in Professional Societies (You may exclude any societies which would indicate race, religion, sex or political affiliation). Please list:

36 Character References (from whom letters of recommendation may be expected):

Name: _____ Address: _____

Position or Title: _____

Number or Years Known to Applicant: _____ Telephone Number: _____

Name: _____ Address: _____

Position or Title: _____

Number or Years Known to Applicant: _____ Telephone Number: _____

Name: _____ Address: _____

Position or Title: _____

Number or Years Known to Applicant: _____ Telephone Number: _____

37 Specialty Board Certification Intent, if known (Name of Board):

38 Future Career Plans, if known:

39 If not a U.S. citizen, do you have the legal right to remain and work in the U.S. for the year(s) for which you are applying?

Yes () No () If you are a non-immigrant, please give your type of visa _____

40 Applicants are requested to submit a 300-word biographical sketch with their application.

Signature of Applicant

Please return completed application to:

UCDMC
Division of Endocrinology, Clinical Nutrition and
Vascular Medicine
4150 V Street, Suite G400
Sacramento, CA 95817 (916) 734-3730 fax 734-7953

Date