

APPLICATION for RESIDENCY
YALE UNIVERSITY SCHOOL of MEDICINE DEPARTMENT of PSYCHIATRY

POSITION BEGINNING _____ PG year APPLYING FOR _____
 year

NAME (LAST) (FIRST) (MIDDLE)		
SOCIAL SECURITY NUMBER		DATE OF BIRTH
PROGRAM APPLYING FOR		
MEDICAL EDUCATION		
MEDICAL SCHOOL(s)		
CITY		STATE/COUNTRY
MONTH/YEAR OF MATRICULATION AT MEDICAL SCHOOL		MONTH/YEAR of (ANTICIPATED) GRADUATION
GRADUATE EDUCATION		
GRADUATE SCHOOL(S)	DATES ATTENDED FROM (MO/YR) TO (MO/YR)	GRADUATE DEGREE (if any)
AREA of STUDY : _____		
NAME		
CITY		STATE
NAME		
CITY		STATE
UNDERGRADUATE EDUCATION		
UNDERGRADUATE COLLEGE(S) MAJOR	DATES ATTENDED FROM (MO/YR) TO (MO/YR)	DEGREE (if any)
NAME		
CITY		STATE
NAME		
CITY		STATE
NAME		
CITY		STATE
PLEASE ATTACH A PERSONAL STATEMENT		
LETTERS of REFERENCE (which should indicate whether or not I have waived access to each letter) , IN ADDITION TO THE DEAN'S LETTER, HAVE BEEN REQUESTED FROM THE FOLLOWING INDIVIDUALS:		
1. Name And Title/ Institution		
Address		
2. Name And Title/ Institution		
Address		
3. Name And Title/ Institution		
Address		

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NAME (LAST) (FIRST)		ATTACH RECENT PHOTOGRAPH (OPTIONAL)
SOCIAL SECURITY NUMBER	ECFMG REGISTRATION (if applicable)	
PARTICIPATE IN NRMP? yes <input type="checkbox"/> no <input type="checkbox"/>	NRMP CODE (enter pending if unknown)	
PRESENT ADDRESS (STREET)		
CITY	STATE ZIPCODE	
PRESENT PHONE NUMBER (S)	VISA STATUS (if applicable) <input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY <input type="checkbox"/> J-1 <input type="checkbox"/> H-1	
NUMBER of DEPENDENTS		
CITIZENSHIP <input type="checkbox"/> U.S. <input type="checkbox"/> OTHER (DESCRIBE)		
PERMANENT ADDRESS C/O (Name of person through whom I can always be contacted)		
STREET		
CITY	STATE ZIPCODE	PERMANENT PHONE NO.
I plan to take the examinations checked below before I begin the graduate medical education program for which I am now applying		
<input type="checkbox"/> USMLE STEP 1	<input type="checkbox"/> USMLE STEP 2 CK	<input type="checkbox"/> USMLE STEP 2 CS <input type="checkbox"/> USMLE STEP 3
I have already passed the examinations checked below on the dates indicated		
<input type="checkbox"/> USMLE Step 1 _____ date	<input type="checkbox"/> USMLE Step 2 (CS) _____ date	<input type="checkbox"/> USMLE Step 2 (CK) _____ date <input type="checkbox"/> USMLE Step 3 _____ date
<input type="checkbox"/> COMLEX Step 1 _____ date	<input type="checkbox"/> COMLEX Step 2 (CS) _____ date	<input type="checkbox"/> COMLEX Step 2 (CK) _____ date <input type="checkbox"/> COMLEX Step 3 _____ date
<input type="checkbox"/> NBME Step 1 _____ date	<input type="checkbox"/> NBME Step 2 _____ date	<input type="checkbox"/> NBME Step 3 _____ date
<input type="checkbox"/> Flex _____ date	STATE(s) of Licensure if applicable	
SERVICE OBLIGATIONS (National Health Service Corps, Armed Forces Scholarships, State Programs, etc.)		
<input type="checkbox"/> I am not required to fulfill any service obligations		
<input type="checkbox"/> I am committed to fulfill a service obligation beginning _____ (mo/yr)		
Number of years committed _____		
I have read and I understand the instructions for the completion of this application. I certify that the information submitted on these application materials is complete to the best of my knowledge. I understand that any false or missing information may disqualify me for this position.		
SIGNATURE OF APPLICANT _____		DATE _____
NOTE: THE SIGNATURE AND DATE ON EACH APPLICATION MUST BE ORIGINAL		