

McGaw Medical Center of Northwestern University
Office of Graduate Medical Education
Application for Admission

Note: Photocopy the completed application for your files. Please notify the Graduate Medical Education office (312/503-7975) and the program office of any change in your address or phone number.	Date of application	Date program to begin
	PGY level at entry <input type="text"/>	

Personal Data

Name: Last	First	Middle	Social Security no.		
Mailing Address: Number and Street			Mailing address and phone current until:		
			Month	Day	Year
City	State	Zip code			
Home phone	Cell phone		Email address		
Permanent address: c/o Name, Number and Street			Permanent phone		
City	State	Zip Code			
		Citizenship	International applicants, specify type of visa you hold		

Matriculation Data

Medical school	Location	Degree	Month	Year
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Program

McGaw Medical Center/Northwestern Memorial Hospital/VA Chicago Health Care System, Chicago, Illinois				
<input type="checkbox"/>	Name of Program			
McGaw Medical Center/Ann and Robert H. Lurie Children's Hospital of Chicago, Illinois				
<input type="checkbox"/>	Name of Program			
McGaw Medical Center/Rehabilitation Institute of Chicago, Illinois				
<input type="checkbox"/>	Name of Program			

Education (List all schools attended)

Institution	Dates attended		Degree conferred	
Include full name and location	From (Mo./Yr.)	To (Mo./Yr.)	Type	Date
Undergraduate				
Medical School				
Graduate work (Other)				

Graduate Medical Education (Include all current and previous graduate medical education)

Postgraduate experience (resident or fellow)	Dates attended		Name of Program Director	Training complete Y/N
All current and previous postgraduate medical education must be verified by the institution at which training occurred	From (Mo./Yr.)	To (Mo./Yr.)		
Name of program and institution				
1)				
Name of program and institution				
(2)				
Name of program and institution				
(3)				
Name of program and institution				
(4)				

During any prior graduate medical education, were you ever disciplined or placed on probation by licensing body, institution, or training program? Y/N

If so, please explain on a separate page to follow.

Other Medical Experience (Include experience such as private practice, hospital and staff appointments, research and military)

Type	Location	Dates

Letters of Recommendation Requested (To be sent directly to the program)

Name	Title	Institution
Name	Title	Institution
Name	Title	Institution

Examinations Taken (Photocopies of original documents with scores and dates must accompany the application)

U.S./Canadian/international medical school graduates			
USMLE	Step 1	Step 2	Step 3
First time pass ?	Y/N	Y/N	Y/N
International medical graduates only			
ECFMG Certificate	Date Issued	No.	
Visa			
Current Status	Type	No.	
Issue date	Expiration date		

Licensure		
State	Temporary No.	Permanent No.
	Date Issued:	Expiration Date
State	Temporary No.	Permanent No.
	Date Issued:	Expiration Date

Have you ever been convicted of a felony? Y/N If, yes please explain on a separate page to follow.

Have you ever been convicted of a misdemeanor? Y/N If, yes please explain on a separate page to follow.

The information I have given in this application is current and complete to the best of my knowledge.	Date
Signature	