

**UNIVERSITY AT BUFFALO
THE STATE UNIVERSITY OF NEW YORK
APPLICATION TO GRADUATE MEDICAL/DENTAL RESIDENCY PROGRAMS**

Position Desired: Resident Fellow: Clinical
 Research

Application for Position in: _____
(Specialty)

Years of Training Desired: _____

Postgraduate Year for Which You Are Applying: I II III IV V VI

Starting Date: _____

Are You Participating In NRMP (National Resident Matching Program)?
 Yes No Number _____

PERSONAL

Name: _____
(Last Name – Surname) (First Name) (Middle Initial) (Social Security Number)

Is additional information relative to change of name, use of assumed name or nickname necessary to enable a check on your work or academic record? If yes, explain: _____

Are you 18 years of age or older? If not, state your age: _____ Are you a citizen of the United States? _____

Present Address: _____

Permanent Address: _____

Work Address: _____

Telephone Number- Work: (____) _____ Home: (____) _____

Can you perform reasonably any task expected of a resident in your residency program? _____

Have you ever been convicted of a crime? Yes No

If so, please explain: _____

Military Service – Current Status and Future Obligation: _____

Branch/Date/Location: _____ Duties: _____

EDUCATION (Official transcript with seal must be sent from all institutions attended excluding high school and college Bachelor's degree*)

Name and Location	Dates Attended	Major	Degree Date
High School/Secondary School: _____	_____	_____	_____
College/University: _____	_____	_____	_____
Graduate School: _____	_____	_____	_____
Medical/Dental School: List all medical schools attended.	Percentile Rank _____	(if available)	
_____	_____	_____	_____
_____	_____	_____	_____
Other Experience: _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*Official transcript required for graduate Medical/Dental education only.

List postgraduate professional experience: (including internship, residencies, and research experience).

Type of Program	Hospital Or Institution	Complete Address Including Country	Supervisor/ Program Director Dates (including telephone/area code)	PGY Level

List other professional institutional/hospital appointments you have held (excluding graduate training):

Hospital	Location (Exact Address)	Department	Dates

LICENSURE

Flex Examination:

(Federal Licensure Exam) Yes No Date Taken _____ Score _____

NBME (National Board of Medical Exams)
(enclose transcript)

Part I Date _____ Score _____

Part II Date _____ Score _____

Part III Date _____ Score _____

USMLE (United States Medical Licensing Examination)

Part I Date _____ Score _____

Part II Date _____ Score _____

Part III Date _____ Score _____

NBDE (National Board of Dental Exams)
(enclose transcript)

Part I Date _____ Score _____

Part II Date _____ Score _____

New York State:

License: Yes No Date Taken _____ Number _____

Temporary Permit: Yes No Date Taken _____ Number _____

Other States:

License: Yes No Date Taken _____ Number _____

Temporary Permit: Yes No Date Taken _____ Number _____

State: _____

PROFESSIONAL LIABILITY/DISCIPLINARY ACTION

Please complete the following questions as part of the credentialing process:

1) Have you ever been dismissed from or the subject of disciplinary action (ie: including termination or probation) while you were in graduate or medical school training? Yes No

If yes, please provide substantive information.

2) Have you ever been the subject of actions resulting from professional misconduct or are there any such cases pending? Yes No

If yes, please provide substantive information.

3) Have there been any settlements or judgments made against you in cases involving medical malpractice or are there any case pending? Yes No

If yes, please provide substantive information.

REFERENCES (under separate cover)

Please forward:

Dean's letter (accompanied by official transcript with seal);

Three professional references (including, if possible, Chief(s) of Service);

Letter from head of clinical service on which you recently served.

I hereby waive access to the above letters and will so inform the authors.

I desire access to the above letters and will so inform the authors.

PERSONAL STATEMENT

Please provide a brief description of your interest in the medical/dental specialty you are applying for as a career and include both your previous and current academic research or interests. In addition, you may desire to briefly note any aspects of your training, experience, or plans not requested in this application which you feel may be of concern to the Selection Committee. (Include honors, publications, and research experience.) Please use additional sheet(s).

I consent to a copy of this application being provided to the entity that employs me if I am accepted into a UB medical/dental residency/fellowship program.

Signature of Applicant: _____ Date: _____
(Must be original)

I certify that the information submitted on these application materials is complete and correct to the best of my knowledge. I understand that false, missing or misleading information may disqualify me for this position and/or if accepted into a graduate medical/dental residency/fellowship program will result in my dismissal from my program.

Signature of Applicant: _____ Date: _____
(Must be original)

PERSONAL STATEMENT

In accordance with federal and state laws, no person in whatever relationship with the State University of New York at Buffalo shall be subject to discrimination on the basis of age, religion or creed, color, disability, national origin, race, ethnicity, sex, or marital or veteran status. Additionally, New York State Governor's Executive Order 28 and the University Board of Trustees Policy prohibit discrimination on the basis of sexual orientation.