East Tennessee State University

James H. Quillen College of Medicine Department of Family Medicine

1. Full Name: _____ Social Security #_____

2. Mailing Address: _____

3. Email Address: _____ DOB: ____-____-____

Gender: ____M ____F Marital Status: _____ Citizenship: _____

Country of Origin: _____ Current Visa Status: _____ Visa#:_____

Expiration: _____ Date of First US Entry: _____

INS Classification held on first Entry: _____

MEDICAL EDUCATION

Institution:_____ Location:_____

Degree: _____ Year: _____

ADDITIONAL POSTGRADUATE EDUCATION

Program _____ Year(s) Attended: _____ City,

State/Province: _____

Country _____

UNITED STATES MEDICAL LICENSING EXAM (USMLE) STATUS

	Dates passed	Passed first attempt?
Step 1	_____	yes _____ no_____
Step 2 Clinical Knowledge	_____	yes_____ no_____
Step 2 Clinical Skills	_____	yes_____ no_____
Step 3	_____	yes_____ no_____

I certify that the information I have given is complete, true, and correct to the best of my knowledge. I also affirm that I have not knowingly withheld any facts or circumstances in completing this data sheet.

Date: _____

Please provide a mail and e-mail address that we can use between now and the IMG Institute to send you educational materials that will better prepare you for program sessions.

Mail address _____ or same as # 2 above _____

E-mail address _____ or same as # 3 above _____

You may return completed form by **fax = 423-439-2440** or

Mail = Dept. Family Medicine, Box 70621, ETSU, Johnson City, TN 37614-1709 Or

Just click the **submit** button below if you have internet connection

Revised: Sep. 11, 2012