ST JOHN HEALTH SM PROVIDENCE

16001 West Nine Mile Road
P. O. Box 2043
Southfield, MI 48073-2043

RECENT PHOTO
(Please staple, tape, or glue.)

(OPTIONAL)

APPLICATION FOR OSTEOPATHIC TRAINING

(PLEASE PRINT OR TYPE)

Name:_____ S.S.#_____

Permanent Home Address:_____
Street City State Zip

Present Home Address:_____
Street City State Zip

Telephone Number(s):_____ / _____
Permanent Number Present Number

D.O.B._____ AOA#_____ E-mail Address:_____
(Optional)

TYPE OF TRAINING REQUESTED:

(Check One) ☐ Internship From:_____ To:_____

☐ Indicate Categorical Residency Preference:_____

If applicable: ☐ Residency_____ From_____ To_____
(Specialty)

Pre-Osteopathic Education:

School	Address (City & State)	Years Attended (Mon. & Yr.)

Degrees Granted:

Degree	Major	School	Date (Mon. & Yr.)

Osteopathic Education:

School	Years Attended (Mon. & Yr.)

Graduation Date:_____

Post-Graduate Training:
(Include all training program dates and residencies)

_____

_____

To be completed by all Applicants:

ALSO INCLUDE: Medical School Dean's letter
Copies of all board scores
Personal Statement
Medical School Transcript

REFERENCES:

List MINIMUM of three Physicians you will contact for reference letters:

1._____ 3._____

2._____ 4._____

BCLS: ☐Yes ☐No Exp. Date_____

ACLS: ☐Yes ☐No Exp. Date_____

Are you a certified Instructor? ☐Yes ☐No

Armed Service obligation? ☐Yes ☐No

Public Health obligation? ☐Yes ☐No

USMLE Scores:

Part I_____

Part II_____

Part III_____

COMLEX Scores:

_____

_____

_____

Michigan License #_____ Exp. Date:_____

DEA #_____ Exp. Date:_____

Authorization for Release of Information To be completed by prospective Resident/Intern:

By applying for appointment to the house staff (intern) of Providence Hospital and Medical Centers, I authorize the Hospital to consult with members of the medical staffs of other Hospitals with which I have been associated and with others who may have information bearing on my competency, character, and ethical qualifications. I furthermore consent to the Hospital's inspection of all records and documents that may be material to an evaluation of my professional qualifications, competency, and moral and ethical qualifications for house staff appointment. I furthermore release from any liability, all representatives of the Hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials; and release from any liability, all individuals and organizations who provide information to the Hospital in good faith and without malice concerning my competence, ethics, character, and other qualifications for house staff appointment, including otherwise privileged or confidential information. I also release from any liability, all representative of the Hospital for their acts performed in good faith and without malice in providing information concerning my competence, ethics, character and other qualifications to other institutions where I may apply for training or privileges.

_____ _____

Signature of Applicant Date

RETURN TO:

OFFICE OF MEDICAL EDUCATION
PROVIDENCE HOSPITAL AND MEDICAL CENTERS
16001 WEST NINE MILE ROAD – PO Box 2043
SOUTHFIELD, MICHIGAN 48037-2043
Phone 248.849.3216 FAX 248.849.5324 Revised:8/16/02