

POSTGRADUATE MEDICAL EDUCATION (Internships, Residencies, etc.)

Type	Hospital or University	Address	Years Attended

HOSPITAL EXPERIENCE OR PRACTICE (other than previously indicated):

Name	Address	Practice
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

RESEARCH INTERESTS AND/OR PUBLICATIONS:

1. _____
2. _____
3. _____

MILITARY EXPERIENCE: _____

HOBBIES AND INTERESTS: _____

MEDICAL LICENSURE:

State	Number	Date Issued
1. _____		
2. _____		
3. _____		

USMLE: Step 1 _____ Step 2 _____ Step 3: _____

ECFMG CERTIFICATE: No. _____ Date Expires: _____ Score: _____

CITIZENSHIP: () U.S.A. () Other: Specify Country: _____

VISA NO: _____ TYPE: _____

REFERENCES: (Includes the Dean of your Medical School, Chief of Staff, physicians, and Directors of Training, when possible.)

Name	Address
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

SUPPORTING DOCUMENTS: A completed application *MUST* include:

1. A notarized copy of medical school diploma
2. A notarized transcript of medical school grades (to be sent directly from your medical school)
3. A statement to include an autobiographical sketch and an explanation of your interest in psychiatry.
4. ECGMC Certificate (IF applicable)

PREFERRED DATES FOR INTERVIEW:

First Choice _____

Second Choice _____

Third Choice _____

Signature Date

Mail the completed application to:

Director of Residency Training
Department of Psychiatry
Division of Child & Adolescent Psychiatry
P.O. Box 100234
Gainesville, FL 32610-0234