

**Internal Medicine Residency Program Application
Categorical PGY-1**

NEW YORK DOWNTOWN HOSPITAL

Name _____
Last First Middle

Permanent Address _____

City State Zip Code

Mailing Address _____
(if different than above)

City State Zip Code

Preferred Phone _____ E-Mail Address _____

Social Security Number: _____ Date of Birth: _____
Month Day Year

US Citizenship?
 Yes No
Country of citizenship _____
Current US visa status (if applicable) _____

US or Canadian Medical Graduate?
 Yes No
ECFMG
Number _____
(if applicable)

Medical School: _____

Dates attended _____ to _____

Prior US Internship/Residency Training: _____

Dates attended _____ to _____

MLE 2-DIGIT SCORES

Step 1: _____

Step 2: _____

Step 2 CSA: _____

Date Passed: _____

Date Passed: _____

Date Passed: _____

Attempts: _____

Attempts: _____

Attempts: _____

(Please attach or send official USMLE transcript)

Biographical Sketch

On a separate sheet of paper, please compose a typed, one page biographical sketch, including relevant experiences, special interests and future plans including your reasons for pursuing your PGY-1 year in our program.

Letters of Reference

In addition to the letter from your medical school dean, you are required to submit three letters of recommendation. These letters should be from individuals who have directly supervised you during your prior education or training. A letter is required from your present or past program director(s), when applicable.

Application Completion

An application is considered complete when we have received the above documentation in addition to (1) your curriculum vitae, (2) your medical school transcript, (3) an official copy of your USMLE transcript(s) (4) a copy of your medical school diploma (if available). When applicable, a valid ECFMG certificate and copy of your permanent alien registration card are required.

Return completed application to:

Graduate Medical Education Office
Department of Medicine
NY Downtown Hospital
170 William Street, Room 715
New York, New York 10038
Phone: (212) 312-5760
Fax: (212) 312-5735

For more information visit our web site at www.nyudh.med.nyu.edu

I certify that the information provided is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me for this position.

Signature

Date