Internal Medicine Residency Program Application, PGY-2 or PGY-3

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 _____

Undergraduate College

_____

Dates attended _____ to _____

Prior US Internship/Residency Training

_____

Dates attended _____ to _____

USMLE 2-DIGIT SCORES

Step 1: _____	Step 2: _____	Step 3: _____
Date Passed:_____	Date Passed: _____	Date Passed: _____
Attempts: _____	Attempts: _____	Attempts: _____

(Attach official copy 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-2 and PGY-3 training in a program different from your PGY-1 year.

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).

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) a copy of your official 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
New York 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.downtownhospital.org

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.