

Application for Residency Program

Name: _____
First *Last* *Middle Initial*

Applying for: PGY2 PGY4 _____ Academic year: _____

Mailing address: _____

Email: _____ Date of birth: _____

Cell phone: _____ Alternate phone: _____

Social Security #: _____ ECFMG registration # (if applicable): _____

Citizenship: _____ Visa status: J-1 H-1 Other specify: _____

If you require a visa, please provide your permanent address in your country of origin:

Have you participated in the NRMP? No Yes If "Yes," when? _____

If "Yes," what is your AAMC ID or other NRMP code? _____

Have you ever been convicted of a felony? Yes No

Are you required to fulfill any service obligations? Yes No If "Yes," beginning when? _____

Undergraduate school(s) attended:

Name: _____ Years attended: _____

City, State and Country: _____ Degree (if any): _____

Name: _____ Years attended: _____

City, State and Country: _____ Degree (if any): _____

Medical and other graduate school(s) attended:

Name: _____ Years attended: _____

City, State and Country: _____ Degree (if any): _____

Name: _____ Years attended: _____

City, State and Country: _____ Degree (if any): _____

Medical and other graduate school(s) attended (cont'd):

Name: _____ Years attended: _____

City, State and Country: _____ Degree (if any): _____

Residency and fellowship program(s) attended:

Name: _____ Years attended: _____

City, State and Country: _____ Degree (if any): _____

Name: _____ Years attended: _____

City, State and Country: _____ Degree (if any): _____

Please provide the following examination results:

Exam	Status <i>(indicate passed, failed, scheduled, or waiting to take)</i>	Date(s) Taken or Scheduled
<input type="checkbox"/> USMLE or <input type="checkbox"/> COMLEX Step 1		
<input type="checkbox"/> USMLE or <input type="checkbox"/> COMLEX Step 2 (Clinical Knowledge)		
<input type="checkbox"/> USMLE or <input type="checkbox"/> COMLEX Step 2 (Clinical Skills)		
<input type="checkbox"/> USMLE or <input type="checkbox"/> COMLEX Step 3		

I certify that the information submitted on this application is complete and accurate. I understand that any false, missing or misleading information may disqualify me for this position.

Signature of Applicant: _____ Date: _____

Additional Documents to be Submitted:

- | | |
|----------------------------------------------------------------------------------------------------------|---------------------------------------|
| (1) CV | (5) USMLE or COMLEX scores |
| (2) Personal Statement | (6) Medical School Dean's Letter |
| (3) Three Letters of Recommendation | (7) Medical School Transcript |
| (4) Letter from Current or Most Recent Program Director outlining completed rotations and Clinical Exams | (8) Medical School Diploma |
| | (9) ECFMG Certificate (if applicable) |

Please see the next page for addresses to use when submitting this form.

Submit this application and the additional documents noted above to:

PGY-2	Attn: Emily Johnson Yale Department of Psychiatry 300 George Street, Suite 901 New Haven, CT 06511	emily.ann.johnson@yale.edu
PGY-4	Attn: Jennifer Dolan-Auten Yale Department of Psychiatry 300 George Street, Suite 901 New Haven, CT 06511	jennifer.dolan-auten@yale.edu