Center for Human Genetics
ELECTRONIC RESIDENCY APPLICATION

Mailing Address:
UT Southwestern Medical Center
McDermott Center for Human Growth and Development
Medical Genetics Residency Program
5323 Harry Hines Blvd.
Mail code: 8591, Rm. NB10.204
Dallas, Tx. 75390-8591
Tel: (214) 648-1600
Fax: (214) 648-1666
e-mail: Susan.Hayes@UTSouthwestern.edu

Optionally, provide a small passport size photograph in this space.

Desired Start Date (mark with an "X")					
	July 1, 2010		July 1, 2011		July 1, 2012

Name: Last	First	Middle	Present Address (Street, City, State, Zip)	
Telephone (Home)	Telephone (Hospital or School)		Email Address	
Permanent Home Address (Street, City, State, Zip)			Name and Address of someone always able to contact you	
Birthday (MM/DD/YYYY)	Place of Birth		Citizenship	If non-citizen, date of entry into US
If non-citizen, type of Visa held (Exchange Visitor, Immigrant, etc.)				

EDUCATION:

High School	Name	From	To	
	City	State	Zip	
	Name	From	To	
	City	State	Zip	
College	Name	From	To	Degree
	City	State	Zip	
	Name	From	To	Degree
	City	State	Zip	
	Name	From	To	Degree
	City	State	Zip	

Graduate School	Name	From	To	Degree
	City	State	Zip	
	Name	From	To	Degree
	City	State	Zip	

If a graduate of a foreign medical school, have you obtained certification from the Educational Commission for Foreign Medical Graduates? _____ Indicate exams passed: ECFMG yes; Visa Qualifying Examination (VQE) _____; Foreign Medical Graduate Exam in the Medical Sciences _____; National Board Exam (parts 1-2-3) _____; United States Medical Licensing Examination (USMLE steps 1-2-3) _____; or FLEX _____. Please enclose notarized copies of your exam results and ECFMG certificate.

Medical School	Name	From	To	Degree
	City	State	Zip	
	Name	From	To	Degree
	City	State	Zip	

Internship, Residency or Fellowship	Hospital	From	To	Field
	City	State	Zip	Program Director
	Hospital	From	To	Field
	City	State	Zip	Program Director
	Hospital	From	To	Field
	City	State	Zip	Program Director
	Hospital	From	To	Field
	City	State	Zip	Program Director

1. Membership in Honorary or Professional Societies, prizes, awards, fellowships, etc. Please include AOA membership. (Beginning with College)

2. Other practice experience, other professional activities or other information you wish us to consider.

3. PROFESSIONAL GOALS AND CAREER PLANS (Omit if included in CV or personal statement).

4. PUBLICATIONS: If applicable, please list publications on a separate sheet.

5. TRANSCRIPT: Please request the Registrar of your Medical College to send a transcript directly to the address at the top of the first page.

6. REFERENCES: Please list four references, of whom one must be the Dean of Students at your school and three must be physicians who can render an evaluation of your professional and academic abilities. Please ask that your recommenders comment on academic and personal attributes such as judgment, industry, interpersonal relationships, capacity to assume responsibility, and professional ethics. Please have these recommendations sent directly to the address at the top of the first page, attention to Medical Genetics Program Director.

Dean of Students	Address
Phone	Email

Other Recommenders 1.	Address
Phone	Email

2.	Address
Phone	Email

3.	Address
Phone	Email

I certify that to the best of my knowledge, the above information is accurate and correct.

Signature and Date _____