LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT & AFFILIATED HOSPITALS
1501 Kings Highway • P.O. Box 33932 • Shreveport, LA 71130-3932
Telephone: (318) 675-5069 / Fax: 318-675-4977

ATTACH THREE (3) PHOTOGRAPHS (no photo copies)

APPLICATION FOR RESIDENCY PROGRAM (Page 1 of 2)

(Beginning Date)________________

CHECK LEVEL: ❒ PGY I ❒ PGY II ❒ PGY III ❒ PGY IV ❒ PGY V ❒ PGY VI

CHECK PROGRAM:

❒ Anesthesiology
❒ Family Medicine
❒ General Surgery
❒ Int. Med. - Categorical
❒ Int. Med. - Pediatrics
❒ Int. Med. - Preliminary
❒ Int. Med. - Primary Care
❒ Obstetrics / Gynecology
❒ Ophthalmology
❒ Oral Surgery
❒ Orthopaedics
❒ Otolaryngology
❒ Pathology
❒ Pediatrics
❒ Psychiatry
❒ Radiology
❒ Urology
❒ ________________
❒ ________________
❒ ________________

PERSONAL INFORMATION:

Name in Full ____ Social Security No.:________________________
Last First Middle

Any other name(s) you have ever been known by:____
Email Address:____
Present Address:______________________________ (Zip)__________ Telephone #:________________
Permanent Address: ______________________________ (Zip)__________ Telephone #:________________
Parent(s) Name and Address:______________________________ (Zip)__________ Telephone #:________________
Citizenship: ______________________________ If not a US citizen - VISA status ________________________(provide copy)
Date of Birth: ______________________________ Place of Birth: ______________________________
Marital Status: ______________________________ If Married, Spouse's given name: ______________________________

(This information is collected to complete equal opportunity reports required by law. You ARE NOT legally obliged to provide this information.)
Racial / Ethnic Group: ______________________________ Sex: ________Male ________Female

EDUCATION:

Premedical - College ______________________________ Major: ______________________________
Degree______________________________ Date of Graduation: (M /D /Y) ______________________________
Medical - School or University____
Degree______________________________ Date of Graduation (M /D /Y) ______________________________
Are you an International Medical Graduate?__________ ECFMG# (attach copy)____________ Date Issued______________ Expires ______________
Licensed to practice medicine in state(s) of ______________________________ License #(s) ______________________________
Dates taken and results of USMLE I____________ , II____________ , III____________ , FLEX____________ , National Board ______________
(attach copies of ALL test results)

ALL APPLICANTS MUST MEET THE LICENSING REQUIREMENTS OF THE LOUISIANA STATE BOARD.

PREVIOUS TRAINING: (If there is a break in training dates, please provide details on a separate sheet.)

Type of Internship:______________________________ Dates: ______________________________
Hospital (name and address):____
Residency (Specialty):______________________________ Dates: ______________________________
Hospital (name and address):____
Memberships (professional / honorary)____

PHYSICIAN REFERENCES: (Supervisor / Preceptor / Program Director / Etc.)

1. Name:____
Address (Street, City, State, Zip) ____
2. Name:____
Address (Street, City, State, Zip) ____
3. Name:____
Address (Street, City, State, Zip) ____

ALL APPLICANTS: Request a copy of your transcript, Dean's letter and three physician reference letters be sent to the PROGRAM DIRECTOR of the program to which you are applying. The program should be referenced and a biographical statement should accompany your application.

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Name ______________________________
(Please Print)

APPLICATION FOR RESIDENCY PROGRAM (Page 2 of 2)

	Yes	No
1. Have you had any physical injury or disease or mental illness or impairment which could reasonably be expected to affect your ability to practice medicine or other health profession?		
2. Have you ever been addicted to or used in excess any drug or chemical substance including alcohol or have you ever been treated through a drug or alcohol rehabilitation program?		
3. Are you now or have you ever been a patient in the psychiatric unit of a hospital/clinic?		
4. Have you ever been charged with, and/or convicted of, pled guilty or nolo contendere to, violation of any municipal, county/parish, state or federal statute? (should not include minor traffic citations)		
5. Has you application for examination or license ever been rejected or denied?		
6. Have you ever failed a licensure / certification examination? How many times ( )		
7. Have you ever been denied membership in a state, county, or local professional society?		
8. Has your membership in a state, county, or local professional society ever been revoked, suspended, placed on probation, or restricted in any manner?		
9. Have you ever been denied, had suspended, revoked or restricted, or voluntarily relinquished staff or clinical privileges in any hospital or health care institution or organization?		
10. Have you had any malpractice claims filed against you within the last five (5) years?		
11. Do you have a Federal or state controlled substance permit? If yes, provide copies.		
12. Have you ever voluntarily surrendered, or did you have suspended, revoked or restricted, your narcotics controlled substances license or registration (state or federal)?		
13. Have you ever voluntarily surrendered, or did you have suspended, revoked, placed on probation, or restricted in any manner, any professional license issued by any licensing authority?		
14. Have you ever been the subject of any type of disciplinary action or inquiry by any licensing agency, hospital, institution, society, etc.?		
15. Have you ever agreed to not seek re-licensure in any licensing jurisdiction?		
16. Have you ever initiated a proceeding, suit, or action against another provider or institution?		
Any “yes” response will require additional documentation on a separate sheet.		

NOTE: You are required to answer every question. Failure to do so will result in a delay or perhaps even cause your appointment to become null and void.
You may be required to provide additional information to complete your application.

In making this application, I fully understand that it is my duty to promptly report any changes in the response(s) to the questions resulting during my practice in this Institution, or any other setting or institution, and that failure to do so shall constitute cause for summary suspension and dismissal from the training program. I do hereby also specifically authorize the hospital and release it, its representatives, and all organizations and individuals who provide information to the hospital from liability in their obtaining information regarding nay changes or potential changes in my response to these questions. I hereby waive all rights I may have against any person, institution, or organization conveying such information or releasing such information to LSU Health Sciences Center.

Applicant’s Signature: ______________________________ *Date:* ______________________