Stony Brook University School of Medicine
Residency in General Preventive Medicine and Public Health

Resident Application

PERSONAL INFORMATION

1. NAME (LAST, FIRST, MIDDLE) ______________________________

2. SOCIAL SECURITY NUMBER ________________________________
   Attach recent photograph

3. DATE OF BIRTH (OPTIONAL) ________________________________
   PLACE OF BIRTH (OPTIONAL) ________________________________
   2” x 2” (optional)

4. CITIZENSHIP
   [ ] U.S.    [ ] Permanent
   [ ] Other ( __________ )    [ ] Temporary (specify)
   [ ] J-1     [ ] H-1

5. VISA STATUS (IF APPLICABLE)
   [ ] U.S.       [ ] Permanent
   [ ] Other ( __________ )    [ ] Temporary (specify)
   [ ] J-1     [ ] H-1

6. PRESENT PHONE NUMBERS
   Day: (____) -  _______  Evening: (____) -  _______
   email address: ___________________________

7. PRESENT ADDRESS
   (street)     (city)   (state)  (zip)
   __________________________________________________________________________

8. PERMANENT ADDRESS
   (Name of person through whom I may always be contacted ______________________ )
   (street)     (city)   (state)  (zip)
   __________________________________________________________________________

9. PERMANENT PHONE NUMBER (____) - _______

10. NUMBER OF DEPENDENTS (OPTIONAL) ______

11. UNDERGRADUATE EDUCATION – Please have official transcript(s) sent directly to Program Director

   UNDERGRADUATE COLLEGE(S)   DATES ATTENDED  MAJOR DEGREE (IF ANY)
   Name  __________________________________ From _____  To _____  ________________________
   Location  ________________________________
   __________________________________
   Name  __________________________________ From _____  To _____  ________________________
   Location  ________________________________
   __________________________________
   Name  __________________________________ From _____  To _____  ________________________
   Location  ________________________________
   __________________________________

12. MEDICAL EDUCATION – Please have official medical school Dean’s Letter and transcript sent directly to Program Director, and please enclose photocopies of all diplomas and training certificates

   MEDICAL SCHOOL   DATES ATTENDED
   Name  __________________________________ From _____  To _____
   Location  ________________________________
   ________________________________

   PREVIOUS RESIDENCY TRAINING PROGRAM(S)   DATES ATTENDED  SPECIALTY
   Institution ________________________________ From _____  To _____  __________________________
   Location  ________________________________
   ________________________________
   Institution ________________________________ From _____  To _____  __________________________
   Location  ________________________________
   ________________________________
13. AT THE TIME I BEGIN THE GRADUATE MEDICAL EDUCATION PROGRAM FOR WHICH I AM NOW APPLYING, I WILL HAVE TAKEN THE EXAMINATION(S) CHECKED BELOW:

<table>
<thead>
<tr>
<th>Number of attempts</th>
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<tbody>
<tr>
<td>USMLE, Part I</td>
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<tr>
<td>USMLE, Part II</td>
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<tr>
<td>USMLE, Part III</td>
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<tr>
<td>NBME, Part I</td>
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<td>NBME, Part II</td>
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<tr>
<td>NBME, Part III</td>
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<tr>
<td>FLEX, Component I</td>
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<tr>
<td>FLEX, Component II</td>
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<tr>
<td>ECFMG, English test</td>
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<tr>
<td>FMGEMS, Part I</td>
</tr>
<tr>
<td>FMGEMS, Part II</td>
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<tr>
<td>ECFMG</td>
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</tbody>
</table>

State(s) of license – please enclose photocopy of license(s)

14. GRADUATE EDUCATION – Please have official transcript(s) sent directly to Program Director

<table>
<thead>
<tr>
<th>GRADUATE SCHOOL(S)</th>
<th>DATES ATTENDED</th>
<th>MAJOR DEGREE (IF ANY) AND AREA OF STUDY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name __________________________</td>
<td>From _____ To _____</td>
<td>__________________________</td>
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<tr>
<td>Location __________________________</td>
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<tr>
<td>Name __________________________</td>
<td>From _____ To _____</td>
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<td>Location __________________________</td>
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15. ADDITIONAL EXPERIENCE

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

16. HONORS/AWARDS

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

17. SERVICE OBLIGATIONS (NATIONAL HEALTH SERVICE CORPS, ARMED FORCES SCHOLARSHIP, STATE PROGRAMS, ETC.)

[ ] I am not required to fulfill any service obligations

[ ] I am committed to fulfill a service obligation beginning ________________________ (month/year) for ________________ (number of years).
18. **GENERAL INFORMATION**

A. Have you ever elected to leave any program of education and/or training prior to completion?
   [ ] YES  [ ] NO

B. Have you ever been asked or directed to leave any program of education and/or training prior to completion?
   [ ] YES  [ ] NO

C. Are there any actions or proceedings that have involved the imposition of a sanction of suspension or dismissal from any program of education and/or training to date?
   [ ] YES  [ ] NO

D. Have you ever pleaded guilty to or been convicted of a crime or offense other than a minor traffic violation?
   [ ] YES  [ ] NO

If YES to any of the above questions, please provide details on a separate page.

19. **IN ADDITION TO A LETTER FROM THE OFFICE OF THE DEAN OF THE MEDICAL SCHOOL FROM WHICH I GRADUATED, THE FOLLOWING INDIVIDUALS (AT LEAST ONE OF WHOM IS A PRIOR PROGRAM DIRECTOR), WHO KNOW MY QUALIFICATIONS WELL, HAVE BEEN ASKED TO WRITE REFERENCES FOR ME.**

Name and Title
__________________________________________________________________________
Institution ___________________________________________________________________
Address _____________________________________________________________________

Name and Title
__________________________________________________________________________
Institution ___________________________________________________________________
Address _____________________________________________________________________

Name and Title
__________________________________________________________________________
Institution ___________________________________________________________________
Address _____________________________________________________________________

(Check one)
[ ] I hereby waive access to the above letters and will so inform the authors.
[ ] I desire access to the above letters and will so inform the authors.

_________________________  ___________________
Signature                   Date

__________________________________________________________________________
Name of applicant (type or print)

STONY BROOK UNIVERSITY IS AN AFFIRMATIVE ACTION/EQUAL OPPORTUNITY EDUCATOR AND EMPLOYER. IF YOU NEED A DISABILITY-RELATED ACCOMMODATION, PLEASE CONTACT THE PREVENTIVE MEDICINE RESIDENCY PROGRAM AT (631) 444-3902.
21. INTERVIEWING SCHEDULING

[ ] The following general time period is most convenient for me

From _______ To _______

[ ] I am able to schedule an interview on the following specific dates

________________________________________

[ ] I am not able to come for an interview

I CERTIFY THAT THE INFORMATION SUBMITTED ON THESE APPLICATION MATERIALS IS COMPLETE AND CORRECT
TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY FALSE OR MISSING INFORMATION MAY DISQUALIFY ME
FOR THIS POSITION.

SIGNATURE OF APPLICANT _____________________________________________  DATE _____________