

DATA SHEET
LSU SCHOOL OF MEDICINE – GME OFFICE

PLEASE PRINT LEGIBLY OR TYPE

(Check one):

Department: _____ House Officer Level _____ Residency or Fellowship
(Level you will be in July)

Training Program Name _____
(State Combined name if is combined Program & Fellowship name if fellowship)

Name: _____
(Last) (First) (Middle)

Mailing Address: _____
(Street) (City) (State) (Zip)

Telephone Number (_____) _____ Beeper Number (_____) _____

Social Security Number ____ - ____ - ____ Citizenship: _____

Date of Birth ____/____/____ Place of Birth: _____

Sex: ___ Male ___ Female Marital Status: S M W D Spouse's Name: _____

Race: (Please check one)
American Native _____ Asian or Pacific Islander _____ Hispanic _____ White _____ Black _____

List Person to Contact in case of Emergency: _____

Relationship: _____ Telephone (_____) _____

This section MUST be completed or form will be returned

EDUCATION:

College: _____ City, State: _____

Dates Attended: _____ Degree: _____

Medical School: _____ City, State: _____

Dates Attended: _____ Degree: _____

Dental School: _____ City, State: _____

Dates Attended: _____ Degree: _____

FMGEM, ECFMG or NBME Number and Date: (please provide us with a copy of your ECFMG Certificate).

Complete Page 2

Revised February 2011

Name: _____

A continuous and inclusive list of internships, residencies, fellowships, staff positions, leave of absences, etc must be provided from Medical School graduation through the current internship, residency or fellowship.

The first entry should be the program you will be training in as of July 1.

Beginning Date (Month/Day/Year): _____

Expected End Date (Month/Day/Year): _____

Program: _____

Facility: _____

City and State: _____

Beginning Date (Month/Day/Year): _____

End Date (Month/Day/Year): _____

Program: _____

Facility: _____

City and State: _____

Beginning Date (Month/Day/Year): _____

End Date (Month/Day/Year): _____

Program: _____

Facility: _____

City and State: _____

Beginning Date (Month/Day/Year): _____

End Date (Month/Day/Year): _____

Program: _____

Facility: _____

City and State: _____

If needed, print another copy of page 2 and attach to the 2-sided copy completed.

Explain any gaps in the above longer than 1 month—use additional pages if necessary.