TRANSFER APPLICATION FROM OTHER INSTITUTION LSU SCHOOL OF MEDICINE – GME OFFICE

PLEASE PRINT LEGIBLY OR TYPE

		(Circle one):
Department:	House Officer Level(Level you will be in July)	Residency or Fellowship
Fraining Program Name/City	mbined Program & Fellowship name if fellows	hip)
Begin Date (Month/Day/Year):	Expected End Date (Month/Day/Ye	ear):
Name:		
(Last)	(First)	(Middle)
Mailing Address:(Street)	(City)	(State) (Zip)
Felephone Number		
Social Security # NPI		
Date of Birth	Place of Birth:	
Sex: Male Female Marital Status:	S M W D Spouse's Nan	ne:
Race: (Please check one) American Native Asian or Pacific lateral		
Relationship:		.)
EDUCATION:		
Medical School:	City,State:	
Dates Attended:	Degree & Date Received:	
Dental School:	City,State	
Dates Attended:	Degree & Date Received:	
MGEM, ECFMG or NBMEE Number and Date:		
Number:	Date:	
A Medical License #	License or Permit Expiration Date:	
f no License, What type of Permit?Intern	PGY2GETP	InterimTempOther
f Other, What type?		
Applicant Signature		Date

Print Name:			Page 2
POST GRADUATI A continuous and in	E TRAINING nclusive list of inte	rnships, residencies, fellowships, staff po	ositions, leave of absences, etc must be provided fellowship. Account for All Time in Chronological
Month/Day/Year Sta	arted:	Month/Day/Year Ended	Specialty:
Hospital/School & P	rogram:		
City and State & Cou	untry if not U.S.:		
Month/Day/Year Sta	arted:	Month/Day/Year Ended	Specialty:
Hospital/School & P	rogram:		
City and State & Cou	untry if not U.S.:		
Month/Day/Year Sta	arted:	Month/Day/Year Ended	Specialty:
lospital/School & P	rogram:		
City and State & Cou	untry if not U.S.:		
Иonth/Day/Year Sta	arted:	Month/Day/Year Ended	Specialty:
lospital/School & P	rogram:		
City and State & Cou	untry if not U.S.:		
Month/Day/Year Sta	arted:	Month/Day/Year Ended	Specialty:
lospital/School & P	rogram:		
City and State & Cou	untry if not U.S.: _		
Explain any gaps USMLE Scores:	in the above lo	onger than 1 month – use addition	nal pages if necessary.
	Score	Number of Attempts	
Step 1			
Step 2 CK Step 2 CS			
Step 2 CS			

Date _____

Applicant Signature _____

Print Name	Page 3

Answer the following questions (Yes answers must be explained. Attach legible explanation)
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		Yes	No
1.	Were you the subject of disciplinary action, placed on academic probation, or asked to undergo additional training or remediation during your professional training (as a student, intern, resident, fellow, or other trainee)?		
	training of remediation during your professional training (as a stadent, metri, resident, renow, or other trainies).		
2.	Was your professional training program extended for any reason?		
3.	Did you leave any professional training program as defined above before completion?		
4.	Did you surrender or fail to renew staff or clinical privileges at any hospital, clinic, or other health care entity		
	In lieu of investigation, while under investigation or while you were the subject of disciplinary proceedings?		
5.	For each program you attended, have you ever had: (write N/A by each that is not applicable or mark Y for those		
	that occurred)		
	Remediation		
	Probation		
	Suspension		
	Non Reappointment		
	Non Promotion		
	Termination		
	Leaving/Left program in lieu of disciplinary action		
	Any other disciplinary activities, If yes, please explain		
6	Have you failed a professional licensure or certification examination (any step/part of FLEX, USMLE, NBME,		
	NBOME, COMPLEX-USA, SPEX/COMVEX-USA or PMLexis)?		
7.	Have you surrendered your state or federal controlled substances permit or registration?		

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Why are you transferring programs?

Applicant Signature _____ Date ____

Print Name	Page 4

Practice History and Non-Professional Activity (Do NOT include Training).

Account for ALL time not specified on previous pages, in chronological order, from Medical School to the present, (Include time off to travel, care for relatives, leave of absences, etc).

From Mo/Day/Yr	To Mo/Day/Yr	City	State or Country	Employer / Practice Setting/(Clinic, Hosp., Solo/Group, Etc.)	Specialty or Activity

Diagon	A + +	Camina	~f +h~	Following:

Curriculum Vitae

Original or Certified Copy of Diploma

Dean's Letter

Residency Diploma (if applicable)

Fellowship Diploma (if applicable)

ECFMG Certificate (if applicable)

Copy of All Current Licenses or Permits

Applicant Signature

DEA Licensure

USMLE Scores (All)

ACGME or CanMEDS Milestones Assessments from the Prior Training Program

I attest that the above information is complete and accurate and I understand any misrepresentations are grounds for
immediate withdrawal of any offer to employee or immediate termination if discovered after my employment begins.

Date _____