## Undergraduate Education
(List every post-secondary college in which you were ever enrolled.)

<table>
<thead>
<tr>
<th>Undergraduate College(s) and Location</th>
<th>Date(s) Attended From (Mo/Yr)</th>
<th>To (Mo/Yr)</th>
<th>Degree</th>
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## Medical Education
(List every medical school in which you were ever enrolled.)

<table>
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<tr>
<th>Medical School(s) and Location</th>
<th>Date(s) Attended From (Mo/Yr)</th>
<th>To (Mo/Yr)</th>
<th>Degree</th>
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## Graduate Education/Residency Training
(List all prior graduate education or residency training in which you were ever enrolled.)

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<tr>
<th>School(s)/Hospital(s) and Location</th>
<th>Date(s) Attended From (Mo/Yr)</th>
<th>To (Mo/Yr)</th>
<th>Type of Training</th>
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### 1. Residency/Fellowship Programs (Please check one):
- □ Anesthesiology
- □ Cardiology
- □ Cardiology-Interventional
- □ Cardiology-Electrophysiology
- □ Critical Care Medicine
- □ Dermatology
- □ Procedural Dermatology
- □ Diagnostic Radiology
- □ Emergency Medicine
- □ Endocrinology
- □ Gastroenterology
- □ Gynecology/Oncology
- □ Hospice & Palliative Medicine
- □ Hematology/Oncology
- □ Infectious Diseases
- □ Internal Medicine-Categorical
- □ Internal Medicine-Preliminary
- □ Nephrology
- □ Neurology
- □ Obstetrics/Gynecology
- □ Orthopaedic Surgery
- □ Pain Medicine
- □ Pediatrics
- □ Plastic Surgery
- □ Podiatric Medicine/Surgery
- □ Psychiatry
- □ Pulmonary Crit.Care Med.
- □ Rheumatology
- □ Surgery-Categorical
- □ Surgical Critical Care
- □ Urology
- □ Urogynecology
- □ Vascular Surgery (Residency)
- □ Vascular Surgery (Fellowship)

### 2. Level of Training Requested:
- □ PGY-1
- □ PGY-2
- □ PGY-3
- □ PGY-4
- □ PGY-5
- □ PGY-6
- □ PGY-7

### 3. Application for Training to Begin: ________________________________
4. **Examination Scores:** *(Please complete all applicable information and provide documentation.)*

| USMLE: | 
|---|---|---|---|---|---|
| Step I: | Step II (CK): | Step II (CS): | Step III: |
| Date: | Date: | Date: | Date: |
| NBPME: | 
| Part I: | Part II: | Part III: |
| Date: | Date: | Date: |
| COMLEX: | 
| Part I: | Part II (CE): | Part II (PE): | Part III: |
| Date: | Date: | Date: | Date: |
| ECFMG: | 
| Basic Medical Science: | Clinical Science: | English: |
| Number: | Month/Year Certified: |

*(Please attach a copy of ECFMG certificate.)*

5. **Visa Information:** *(H1-B not accepted)*

- J-1 or EAD: 
- Expiration Date:

6. **Citizenship:**

7. **Please Answer the Following Questions:**

   A. Have you ever been denied a license to practice medicine or eligibility to sit for a licensing exam in this state or any other state? ◯ Yes ◯ No

   B. Have you ever been denied eligibility to participate in a graduate medical education program in this state or any other state? ◯ Yes ◯ No

   C. Have you ever been asked to resign, or have you ever been discharged/terminated from a graduate medical education program? ◯ Yes ◯ No

   D. Have you ever been convicted of a crime, offense, or misdemeanor in this state or any other state? ◯ Yes ◯ No

   E. Are you now, or have you ever been the subject of a criminal proceeding in this state or any other state? ◯ Yes ◯ No

   F. Have you ever had your privilege to participate in any state or federal medical assistance program (i.e. Medicare, Medicaid) curtailed or limited by any regulatory authority? ◯ Yes ◯ No

   G. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain. ◯ Yes ◯ No

*(If you answered yes to any of the above questions, please attach a written detailed explanation.)*

8. **Attach Two Passport Size Photographs**

9. **Letters of Recommendation:** Three letters of recommendation are required, including one letter from the Dean. Individuals currently in a residency program or who have completed training must provide a letter from the program director. Contact your program coordinator for any additional required documents.

10. **Transcripts:** Original transcripts verifying undergraduate education and medical school must be submitted with the official seal. Residency training certificate/diploma must also be submitted with a notarized seal.

11. **Curriculum Vitae:** Submit a CV to include a list of all activities chronologically, with the month and year of the start of medical education to the present. Include all periods of unemployment and/or gaps in training.

12. I understand that the information on this application is subject to verification by Cooper University Hospital. I hereby authorize Cooper to do so and I further authorize all institutions, individuals, hospitals, or organizations to release any information requested. I hereby release from liability and damages those institutions, individuals, hospitals, and organizations who provide such information. I certify that all information provided herein is true and correct. Falsification, misrepresentation, or omissions from this application will be cause for immediate termination.

Signature of Applicant: __________________________ Date: __________________

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*Return completed application, education documents, and letters of recommendation to:*

Program Director; Department in which residency is requested · Cooper University Hospital · One Cooper Plaza · Camden, NJ · 08103-1489

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*Cooper University Hospital* · *Cooper Medical School of Rowan University* · One Cooper Plaza · Camden, NJ 08103 · Tel 856-342-2922 · Fax 856-968-8417

Revised 9/14