

# DEPARTMENT OF DEFENSE APPLICATION FOR GRADUATE MEDICAL EDUCATION

FOR OFFICE USE ONLY

THIS FORM IS AFFECTED BY THE PRIVACY ACT OF 1974

1. AUTHORITY: 10 USC 3012
2. PRINCIPLE PURPOSE(S): TO COMPILE INFORMATION NECESSARY TO EVALUATE AN APPLICATION FOR MILITARY GRADUATE MEDICAL EDUCATION (GME) TRAINING
3. ROUTINE USES: TO EVALUATE APPLICATION FOR PROFESSIONAL TRAINING IN THE MILITARY AND CIVILIAN FACILITIES (MEDICAL CORP OFFICERS ONLY)
4. MANDATORY OR VOLUNTARY DISCLOSURE: DISCLOSURE OF REQUESTED INFORMATION IS VOLUNTARY HOWEVER, WITHOUT IT CONSIDERATION FOR GME MAY NOT BE ASSURED

## PERSONAL/CONTACT INFORMATION

LAST NAME		FIRST NAME				MI
GENDER	RACE	DATE OF BIRTH	SSN		EDIPI (DoD ID) Number	
MARITAL STATUS	BRANCH OF SERVICE	PAY GRADE	US CITIZEN YES NO	US BORN YES NO	BIRTH CITY/STATE/COUNTRY	
HOME ADDRESS			PLACE OF DUTY OR MEDICAL SCHOOL ADDRESS			
HOME OR CELL PHONE		DUTY PHONE (IF APPLICABLE)		IF MARRIED, IS SPOUSE ACTIVE DUTY? Spouse's Full Name:		YES NO
PREFERRED E-MAIL ADDRESS			SSN:	Pay Grade:	Service:	
			Duty Station:			

If you answer "YES" to any of the below questions, explain on the last page.

Have you ever been convicted of a misdemeanor?	YES	NO
Have you ever been convicted of a felony?	YES	NO
Have you ever been disciplined for student conduct violations (e.g., academic probation, dismissal, suspension, disqualification, etc.) by any college or school?	YES	NO
Have you ever been disciplined for student academic performance (e.g., academic probation, dismissal, suspension, disqualification, etc.) by any college, school, or internship/residency program?	YES	NO
Do you have any extenuating circumstances for the board to consider?	YES	NO

## EDUCATION

UNDERGRADUATE SCHOOL		UNDERGRAD HONORS:			
MAJOR					
GPA	GRAD OR COMPLETION DATE				
MEDICAL SCHOOL		MEDICAL SCHOOL HONORS			
GPA	AAMC ID				
CLASS RANK	CLASS SIZE	GRAD OR COMPLETION DATE			
PLEASE INDICATE APPROPRIATE DOCTORATE MD DO			SCHOLARSHIP PROGRAM HSCP HPSP USU ROTC FAP		

## OTHER POST GRADUATE SCHOOLS

SCHOOL:		SCHOOL:			
DEGREE:	GRAD DATE:	DEGREE:	GRAD DATE:		

### ECFMG CERT NUMBER (IF APPLICABLE)

Cert Number: \_\_\_\_\_ Date: \_\_\_\_\_

LAST NAME	FIRST NAME	MI	SSN
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**PGY-1 ROTATIONS**

FILL OUT **ONLY** IF YOU ARE APPLYING FOR A RESIDENCY AND **DID NOT** COMPLETE A CATEGORICAL INTERNSHIP IN THAT SPECIALTY.  
**DO NOT** COMPLETE IF YOU ARE APPLYING FOR A FELLOWSHIP.

SPECIALTY	NUMBER OF WEEKS	SPECIALTY	NUMBER OF WEEKS
SPECIALTY	NUMBER OF WEEKS	SPECIALTY	NUMBER OF WEEKS
SPECIALTY	NUMBER OF WEEKS	SPECIALTY	NUMBER OF WEEKS
SPECIALTY	NUMBER OF WEEKS	SPECIALTY	NUMBER OF WEEKS
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SPECIALTY	NUMBER OF WEEKS	SPECIALTY	NUMBER OF WEEKS
SPECIALTY	NUMBER OF WEEKS	SPECIALTY	NUMBER OF WEEKS
SPECIALTY	NUMBER OF WEEKS	SPECIALTY	NUMBER OF WEEKS

**LICENSURE/CERTIFICATION**

SPECIALTY BOARD CERTIFICATION		INDICATED SPECIALTY BOARD CERTIFICATION		DATE:
YES	NO			
MEDICAL LICENSING EXAMINATION			<b>*COPIES OF RESULTS FOR ALL STEPS/LEVELS 1-3 MUST BE SUBMITTED WITH THIS APPLICATION*</b>	
FLEX	NBME/USMLE	NBOME/COMLEX		
<b>*LIST OTHER STEPS/LEVELS 1-3 ON LAST PAGE.*</b>				IF ANY STEPS/LEVELS NOT PASSED OR TAKEN, PLEASE EXPLAIN
STEP/LEVEL 1	YEAR TAKEN			
PASS FAIL PENDING SCORE				
STEP/LEVEL 2	YEAR TAKEN			
PASS FAIL PENDING SCORE				
STEP/LEVEL 3	YEAR TAKEN			
PASS FAIL PENDING SCORE				
I POSSESS A CURRENT UNRESTRICTED MEDICAL LICENSE: YES NO STATE LIC NUMBER EXP DATE				

**MILITARY TRAINING**

PGY-1 SPECIALTY	LOCATION	COMPLETION DATE
RESIDENCY SPECIALTY	LOCATION	COMPLETION DATE
FELLOWSHIP SPECIALTY	LOCATION	COMPLETION DATE

**MILITARY ASSIGNMENT HISTORY**

FROM	TO PRESENT	DUTY STATION	DUTY TITLE
FROM	TO	DUTY STATION	DUTY TITLE
FROM	TO	DUTY STATION	DUTY TITLE

CURRENT PROGRAM DIRECTOR

CURRENT SUPERVIOR

**PRIOR MILITARY SERVICE**

PRIOR MILITARY SERVICE		HONORABLE DISCHARGE (IF NO, EXPLAIN)		
YES	NO	YES	NO	
FROM	TO	BRANCH	PAY GRADE	OCCUPATION OR SPECIALTY
FROM	TO	BRANCH	PAY GRADE	OCCUPATION OR SPECIALTY

**REQUESTED SPECIALTIES**

CURRENT STATUS	OTHER (SPECIFY)	TRAINING TYPE	START YEAR REQUESTED
PRIMARY SPECIALTY REQUESTED <i>(Type in space if not listed)</i>		SECONDARY SPECIALTY REQUESTED <i>(Type in space if not listed)</i>	
SUB-SPECIALTY REQUESTED <i>(Type in space if not listed)</i>		SUB-SPECIALTY REQUESTED <i>(Type in space if not listed)</i>	

PGY-1 applicants: Check here to opt-out of consideration for straight through training in your first choice specialty

Pilot Program Participation for first choice specialty, opting out of straight through training to PGY2

**TRAINING LOCATION PREFERENCES**

PLEASE RANK YOUR PRIMARY AND SECONDARY LOCATIONS IN ORDER OF PREFERENCE

PRIMARY SPECIALTY	SECONDARY SPECIALTY
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.

**PAPERS/ACHIEVEMENTS**

List any of the following: Military Honors, Professional Societies, Academic Appointments, Volunteer Information, Peer & Non-Peer Reviewed Publications, Research Participation/Presentations and Leadership Positions. **Can attach CV. EACH SECTION LIMITED TO 5,000 CHARACTERS**

**MILITARY HONORS** *(continue in comments):*

**PROFESSIONAL SOCIETIES** *(continue in comments):*

**ACADEMIC APPOINTMENTS** *(continue in comments):*

LAST NAME	FIRST NAME	MI	SSN
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**VOLUNTEER INFORMATION** *(continue in comments):*

**PEER & NON-PEER REVIEWED PUBLICATIONS** *(continue in comments):*

**RESEARCH PARTICIPATION & PRESENTATIONS** *(continue in comments):*

**LEADERSHIP POSITIONS** *(continue in comments):*

I UNDERSTAND THAT THE GME TRAINING RECEIVED IS DIRECTED TOWARD BOARD CERTIFICATION. I AM FAMILIAR WITH THE TRAINING REQUIREMENTS FOR BOARD CERTIFICATION IN THE SPECIALTY FOR WHICH I HAVE APPLIED. IT IS UNDERSTOOD THAT I MUST ENTER A PROGRAM THAT IS ACCREDITED AND LISTED IN GOOD STANDING WITH THE MOST CURRENT GRADUATE MEDICAL EDUCATION DIRECTORY PUBLISHED BY THE AMERICAN MEDICAL ASSOCIATION OR IF APPLICABLE (GENERALLY PGY-1 LEVEL OF GME) BY THE MOST CURRENT YEARBOOK AND DIRECTORY PUBLISHED BY THE AMERICAN OSTEOPATHIC ASSOCIATION.  
 I UNDERSTAND THAT I MUST ALSO MEET THE REQUIREMENT TO SIT FOR THE CERTIFICATION EXAMINATION BY THE RESPECTIVE SPECIALTY BOARD WHICH IS RECOGNIZED BY THE AMERICAN BOARD OF MEDICAL SPECIALTIES. FOR THOSE SUB-SPECIALTIES WHICH DO NOT LEAD TO BOARD CERTIFICATION, NOR ACCREDITATION STATUS, TRAINING MUST BE RECEIVED IN A PROGRAM APPROVED BY THE APPROPRIATE SPECIALTY SOCIETY. I UNDERSTAND THAT MY SERVICE OBLIGATION FOLLOWING SCHOOLING WILL BE COMPUTED IN ACCORDANCE WITH APPLICABLE SERVICE REGULATION AND DOD DIRECTIVES AND THAT I WILL BE MADE AWARE OF MY EXACT OBLIGATION PRIOR TO ENTERING GME TRAINING. I ACKNOWLEDGE THAT I UNDERSTAND THE CONTENTS OF THIS APPLICATION AND I AFFIRM THAT THE INFORMATION GIVEN IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I AM AWARE THAT I MUST SUBMIT ALL SUPPORTING DOCUMENTS REQUIRED BY THE MILITARY SERVICE FOR WHICH I AM ASSIGNED FOR THIS APPLICATION TO BE COMPLETE.

<b>APPLICANT SIGNATURE:</b>	<b>DATE:</b>
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LAST NAME

FIRST NAME

MI

SSN

**ADDITIONAL COMMENTS (PLEASE LIST BY SECTION)**

NAVY MEDICINE

GRADUATE MEDICAL EDUCATION

PRIVACY STATEMENT / INFORMATION RELEASE

I \_\_\_\_\_ hereby authorize Navy Medicine and Naval Medical Leader and Professional Development Command release authority of my name, selected specialty, and training location that was determined at the conclusion of the Joint Service Graduate Medical Education Selection Board. I understand that the release of information described herein will be solely to report my DoD-sponsored GME selection status to my administrative office (HPSP, HSCP, USUHS, PDS), specialty leader, and the training facility for which I was selected.

This information is protected under the Privacy Act of 1974 5 USC 552a, and its content shall not be disclosed, discussed, or shared with individuals unless they have a direct need-to-know in the performance of their official duties

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date