LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER-SHREVEPORT & AFFILIATED HOSPITALS
1501 KINGS HWY, P.O. BOX 33932
SHREVEPORT, LA 71130-3932

ATTACH THREE (3) ORIGINAL PHOTOGRAPHS

APPLICATION FOR RESIDENCY/FELLOWSHIP PROGRAM (PAGE 1 OF 2)

Start Date: _____ **Mark appropriate level**: ☐ PGY I ☐ PGY II ☐ PGY III ☐ PGY IV ☐ PGY V ☐ PGY VI

Training Program:

☐ Anesthesiology	☐ Emergency Medicine	☐ Family Practice – Alexandria
☐ Family Practice – S'port	☐ Internal Medicine – Cat.	☐ Internal Medicine – Prelim.
☐ Medicine/Pediatrics	☐ Neurosurgery	☐ Obstetrics & Gynecology
☐ Ophthalmology	☐ Oral Surgery	☐ Orthopaedics
☐ Otolaryngology	☐ Pathology	☐ Pediatrics
☐ Psychiatry	☐ Radiology	☐ Surgery
☐ Urology	☐ Fellowship (Specify Program): _____	

Personal Information: *Please Type or Print Legibly*

Name in Full _____ Social Security Number: _____
Last First MI

Any other name(s) you have ever been known by: _____
Present Address: _____ Zip Code: _____ Phone: _____
Street City State
Permanent Address: _____ Zip Code: _____ Phone: _____
Street City State
Emergency Contact: _____ Zip Code: _____ Phone: _____
Street City State

Citizenship: _____ If not a U.S. Citizen – VISA status (provide copy) _____
Date of Birth: _____ Place of Birth _____ Martial Status ___ Spouse's Name _____

This information is collected to complete equal opportunity reports required by law. You are not legally required to provide this information.
Racial/Ethnic Group _____ Sex (Circle One): M F

Education:

Premedical: School: _____ Major: _____ Degree: _____
Address _____ Zip Code: _____ Graduation Date: _____
Street City State (M/D/Y)
Medical: School: _____
Street City State Zip Code Country
Degree: _____ Graduation Date (M/D/Y): _____ IMG (Circle One): Yes or No

IMG: ECFMG No. _____ Issue Date _____ Expiration Date _____

Examination Results: USMLE I _____ USMLE II _____ USMLE III _____
ATTACH COPIES OF ALL TEST RESULTS Date taken/Score Date taken/Score Date taken/Score

Other Examination Results (i.e. COMLEX): _____
Type of Exam Date taken/Score

Licensed to practice medicine in state(s) of _____ License #(s) _____

ALL APPLICANTS MUST MEET THE LICENSING REQUIREMENTS OF THE LOUISIANA STATE BOARD OF MEDICAL EXAMINERS (LSBME).

Previous Training: (If there is a break in training, a detailed explanation must be provided on a separate sheet)

Internship (Specialty) _____ Dates _____ Name of Hospital _____
Address: _____
Street City State Zip Code
Residency (Specialty) _____ Dates _____ Name of Hospital _____
Address: _____
Street City State Zip Code

Physician References (Training Program Director, Supervisor, Preceptor, etc.)

1. Name _____ Address: _____
2. Name _____ Address: _____
3. Name _____ Address: _____

ALL APPLICANTS – Medical school transcript, Dean's letter, three (3) reference letters, and a personal statement/CV need to be sent to the Program Director of the program to which you are applying.

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		Yes	No
1.	Have you had any physical injury or disease or mental illness or impairment which could reasonably be expected to affect your ability to practice medicine or other health profession?	_____	_____
2.	Have you ever been addicted to or used in excess any drug or chemical substance including alcohol or have you ever been treated through a drug or alcohol rehabilitation program?	_____	_____
3.	Are you now or have you ever been a patient in the psychiatric unit of a hospital/clinic?	_____	_____
4.	Have you ever been charged with, and/or convicted of, pled guilty or nolo contendere to, violation of any municipal, county/parish, state or federal statute? **(Should not include minor traffic citations).**	_____	_____
5.	Has your application for examination or license ever been rejected or denied?	_____	_____
6.	Have you ever failed a licensure/certification examination? If yes, how many times? _____	_____	_____
7.	Have you ever been denied membership in a state, county, or local professional society?	_____	_____
8.	Has your membership in a state, county, or local professional society ever been revoked, suspended, placed on probation, or restricted in any manner?	_____	_____
9.	Have you ever been denied, had suspended, revoked, or restricted, or voluntarily relinquished staff or clinical privileges in any hospital or health care institution or organization?	_____	_____
10.	Have you had any malpractice claims filed against you within the last five (5) years?	_____	_____
11.	Do you have a Federal DEA or Louisiana controlled substance permit? If yes, provide copies.	_____	_____
12.	Have you ever voluntarily surrendered, or did you have suspended, revoked or restricted, your narcotics controlled substance license(s) or registration (state or federal)?	_____	_____
13.	Have you ever voluntarily surrendered, or did you have suspended, revoked, placed on probation, or restricted in any manner, any professional license issued by any licensing authority?	_____	_____
14.	Have you ever been the subject of any type of disciplinary action or inquiry by any licensing agency, hospital, institution, society, etc.?	_____	_____
15.	Have you ever agreed to not seek re-licensure in any licensing jurisdiction?	_____	_____
16.	Have you ever initiated a proceeding, suit, or action against another provider or institution?	_____	_____

Any 'yes' response will require a detailed explanation on a separate sheet. Failure to provide an explanation will result in an incomplete application.

NOTE: You are required to answer every question. Failure to do so will result in a delay and may cause your appointment to become null and void. *You may be required to provide additional information to complete your application.*

In making this application, I fully understand that it is my duty to promptly report any changes in the response(s) to the questions resulting during my practice in this institution, or any other setting or institution, and that failure to do so shall constitute cause for summary suspension and dismissal from the training program. I do hereby also specifically authorize the hospital and release it, its representatives, and all organizations and individuals who provide information to the hospital from liability in their obtaining information regarding any changes or potential changes in my response to these questions. I hereby waive all rights I may have against any person, or organization conveying such information or releasing such information to LSU Health Sciences Center-Shreveport.

Applicant Signature: _____ Date: _____

Applicant Printed Name: _____