ONMM3 Residency Appliciation

Edward Via College of Osteopathic Medicine, Virginia Campus
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Phone: 540 231-3617, Fax: 540 231-2001

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Date:	
Name:	
Address:	
State/Province:	
Zip/Postal Code:	
SS Number:	
Email:	
Home Phone:	
Cell Phone:	

Please attach recent photograph

For academic year:

Military Service Obligation/Deferment?

☐ **Yes**	☐ **No**	**Years**	
Military Branch:			
Other Service Obligation:		**Description**	
Citizenship:		**If not US Citizen, Visa Type:**	

State Medical Licenses:

Type	Number	State	Exp. Date

Has your license ever been revoked? ☐ yes ☐ no If yes, please explain in the additional comments section

Education

Type of School	Name of School and Complete Mailing Address	Years Completed	Major or Degree
College/University			
Medical School			
Professional School			

Have you ever been convicted of a crime? ☐ **Yes** ☐ **No**

If yes, please explain:

Do you have a driver's license? ☐ **Yes** ☐ **No**

State of issue: ☐

Have you had any accidents in the past 3 years?	☐ **Yes** ☐ **No**	**How many?**	
Have you had any moving violations in the past 3 years?	☐ **Yes** ☐ **No**	**How many?**	

Internship/Residency:

1.

Internship:		
Program Director:		
Dates of internship:	**From:**	**To:**
Complete Address:		
Phone #		
Rotations:		
Discipline:		
Reason for leaving:		

2.

Internship:		
Program Director:		
Dates of internship:	**From:**	**To:**
Complete Address:		
Phone #		
Rotations:		
Discipline:		
Reason for leaving:		

Have you ever had any interruption in your training (undergraduate through residency)?

☐ **Yes** ☐ **No –** if yes, please explain in the additional comments section

NMM/OMM/ONMM Rotations:

Please list dates, type, location, instructor:

Musculoskeletal Rotations (SM, Ortho, Neuro surg, podiatry, occ med, rheum, PM&R, MSK rad, other rad, regen med, phys therapy):

Please list dates, type, location, instructor:

OMM & OPP Conferences

Please note attended/presented

Previous Practice Experience

	Examination:	**Status**	**Date:**	**Score (3/2 digits):**
I				
II				
III				

Medical Licensure:

ACLS ☐ **Yes** ☐ **No** **Exp. Date** **PALS** ☐ **Yes** ☐ **No** **Exp. Date**

DEA Reg # **Exp. Date**

Board Certification ☐ **Yes** ☐ **No** Name

Medical License Problem? ☐ **Yes** ☐ **No** Reason

Ever named in a malpractice suit? ☐ **Yes** ☐ **No** Reason

Past History: ☐ **Yes** ☐ **No** **Explanation**

Education Commission for Foreign Medical Graduate Certification:

ECFMG Certified: ☐ **Yes** ☐ **No** **Certification Date**

Honors/Awards:

Previous Employment (list up to 3)

1.

Name of Employer:		
Name of last Supervisor:		
Dates of Employment:	**From: Date**	**To: Date**
Salary	**Beginning:**	**Ending:**
Complete Address:		
Phone #:		
Last job title:		

Reason for leaving (Be Specific!)

List jobs held, duties performed, skills used or learned, advancements, or promotions while employed:

May we contact this employer? ☐ **Yes** ☐ **No**

2.

Name of Employer:		
Name of last Supervisor:		
Dates of Employment:	**From: Date**	**To: Date**
Salary	**Beginning:**	**Ending:**
Complete Address:		
Phone #:		
Last job title:		

Reason for leaving (Be Specific!)

List jobs held, duties performed, skills used or learned, advancements, or promotions while employed:

May we contact this employer? ☐ **Yes** ☐ **No**

3.

Name of Employer:		
Name of last Supervisor:		
Dates of Employment:	**From: Date**	**To: Date**
Salary	**Beginning:**	**Ending:**
Complete Address:		
Phone #:		
Last job title:		

Reason for leaving (Be Specific!)

List jobs held, duties performed, skills used or learned, advancements, or promotions while employed:

May we contact this employer? ☐ **Yes** ☐ **No**

Please list 3 references:

	1	2
Telephone		
Name		
Position		
Company		

	3
Telephone	
Name	
Position	
Company	

Additional Comments:

Certification Statement:

I have read and understand the instructions and other information of this application. I certify that the information recorded herein is complete and accurate to the best of my knowledge. I recognize that any intentional misrepresentation on my part may cause me to be disqualified from continuation in the application process and/or to be denied appointment to or dismissal from the medical education program.

I hereby authorize VCOM, its staff and their representatives, to consult with my peers and others who may have information bearing on my current professional competence, character, health status, ethical qualifications and ability to work cooperatively with others and consent to the release of such information to and by them.

I further consent to the inspection, by VCOM, its staff and their representatives, of all documents that may be material to an evaluation of my qualifications and current competencies and consent to the release of such information to them.

Applicant Signature	**Date**

Trainees are selected on the basis of academic and personal qualifications regardless of race, sex, color, religion, national origin or marital status.