

# ONMM3 Residency Appliciation

Edward Via College of Osteopathic Medicine, Virginia Campus 1691 Innovation Dr Ste 1300 Blacksburg VA 24060 Phone: 540-231-9673

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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 Obl	igation:		Description	
Citizenship:		If not US Citiz	en, Visa Type:	

### **State Medical Licenses:**

Туре	Number		State	Exp. Date
Has your license ever been revo	ked? 🗌 yes 🗌 no	If yes, pleas	e explain in the additic	onal 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
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## 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:	То:	
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)?

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

#### NMM/OMM/ONMM Rotations:

Yes

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):
L				
П				
Ш				

Medical Licensure: ACLS Yes No	Exp. Date	PALS 🗌 Yes 🗌 No	Exp. Date
DEA Reg # Board Certification	Yes No	<b>Exp. Date</b> 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: **Certification Date** 

Yes No **ECFMG Certified:** 

### Honors/Awards:

# **Previous Employment (list up to 3)**

L.			
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
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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 Sp	ecific!)		

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 Spe	cific!)		

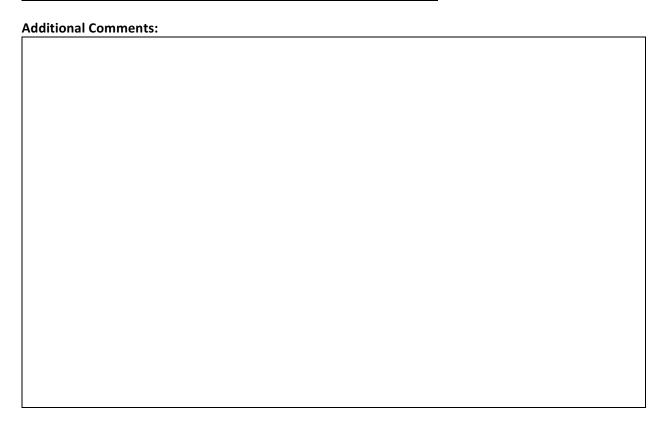
List jobs held, duties performed, skills used or learned, advancements, or promotions while employed:

May we contact this employer? Yes No	

# Please list 3 references:

	1	2
Telephone		
Name		
Position		
Company		
	3	

	5
Telephone	
Name	
Position	
Company	



## **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.

Revised 10/2019